ST MARK'S HOSPITAL ANNUAL REPORT 2014 & 2015

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2014 & 2015

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Preface

Peter McDonald
Consultant Surgeon

This report may be tardy and we may have failed again in our attempt to publish unbroken Annual Reports but this 2014 & 2015 St Mark's Annual Report is, despite this, a most worthy latecomer to the archives of St Mark's Hospital.

Steve Preston deserves much praise for tenaciously putting this weighty document together. He has worked tirelessly to cajole Departmental Heads and individuals to report on their activities. The result is a document that gives the reader, present or many years into the future, a clear idea what an active and exciting place St Mark's Hospital was to work in during those years. Steve's commitment to this project speaks to me, as one of the old lags, of the enthusiasm, which this little hospital engenders in its staff. St Mark's Hospital may be small but it is beautiful and, unlike many hospitals in the modern age, is still a family of health care professionals who delight in the work they do together and in the succour they bring to their many patients.

There is much in this report of interest but let me highlight two gems. In the Heritage Committee section there is a most fascinating insight into the history of the earliest times of the old hospital in City Road. It includes the earliest known photograph of surgeons at work at our theatre there. This is an extraordinary archive and matches the 1930 film of Percy Lockhart-Mummery performing a perineal sigmoidectomy and colostomy that I have shown many times in the UK and abroad. This chapter contains also John Northover's masterful account of his final few days and weeks working at St Mark's. After forty years in the NHS and nearly thirty as a Consultant Surgeon, his story of his final denouement and tramp home on foot is priceless. Observational writing does not get

better than this and if you have time only to read one thing in our little tome, let it be this.

Whether you are staff, a patient or a visitor to St Mark's Hospital there is much in the Annual Report 2014 & 2015 to both enjoy and inform. Indeed, there is plenty of wisdom in these pages as well as documentary evidence of the hospital's efforts to keep its reputation as the cradle of coloproctology and the oldest specialist bowel hospital on the planet.

Peter McDonald
Consultant Surgeon

Introduction

Steve Preston
Multimedia Consultant

In the last Annual Report of 2010 & 2011, Peter McDonald rather forlornly declared a four year hiatus since the last publication, that being 2006. At that time, a concerted effort was made to catch up, it being the first to cover two consecutive years. Unfortunately, history has repeated itself! I have to admit I had never previously given the Report a great deal of thought before it came to me to deliver this latest edition, as it was always handled by others and produced by an external company. I did however look through each one and find interest in the content. Since I have become heavily involved in the history and heritage aspect of the hospital, now in its own section in this book, and started a little cottage industry producing medical books for the institution (see Ileo-Anal Pouch Surgery for Ulcerative Colitis by Zarah Perry-Woodford and very shortly Essential Stoma Care from Jennie Burch and Pat Black), the Annual Report started to become something of an icon in St Mark's publishing to me.

I investigated its history and availability in January 2017, and was rather shocked to discover that apart from the Barts archive in central London, we only have a set of Reports from 1948 onwards on site, and in many of those cases, one single precarious edition. These booklets are scattered around various rooms, mostly on Level 5, and I would like to declare an interest in bringing them together for safe-keeping, and also a long held desire to have them all digitally scanned for longevity and research purposes. Time is the issue, and time rather than enthusiasm has been the barrier to getting previous reports published in recent years, and now we have a definite gap of knowledge, that being 2007–2009 and 2012–2013. What makes this an incredible shame is that up until 2007, the

Hospital had a complete run of reports going back to Frederick Salmon's first issue in 1835, all of which are currently held in bound volumes in a temperature-controlled basement archive at Barts.

Here is an excerpt on that history from Lindsay Granshaw's indispensible volume 'St Mark's Hospital, London – A Social History of a Specialist Hospital': *At the end of the first year, the Infirmary issued its first publication, the forerunner of its Annual Reports. It was entitled List of Subscribers to the Infirmary for the Relief of the Poor Afflicted with Fistula and Other Diseases of the Rectum. Its title reflected its main purpose: to attract further donations. The List and subsequent Annual Reports were not designed to convince the medical profession of the value of the hospital's work or even to inform potential patients of what the hospital had to offer. Instead they aimed to encourage the charitably-minded to part with their money. The hospital could not hope to continue.*

So I believe this '2014 and 2015' edition holds a great importance in its own way, as by its very existence it is declaring that it refuses to vanish into history. I also think the remit of the Annual Report goes far beyond this original intention as solely a fundraiser. It brings to the reader a window into St Mark's, describing the important work being undertaken by each department, providing us with detailed lists of staff, and an extensive reference section for published works, representing the best of our output. It provides us with a useful historical document, one that can be utilised by staff, researchers and historians alike, to explore a moment in time. It creates a sense of self, a sense of place, it shows pride in what we do and how we go about our work. It binds together departments into one place, showing a singular vision and a defined sense of multidisciplinary teamwork. It encourages our staff to produce great research, to work to their best abilities, by showing each other what we have achieved. It places today into the context of our history. And of course it can still be used to encourage donations to ensure our future.

I can't pretend it has been an easy process to compile this edition, it is with some difficulty I have obtained many of the pages within this book from the various departments, and that is not due to anything other than the pressures of extremely busy professionals finding it incredibly hard to find time for one more task that otherwise doesn't appear to be time sensitive or as vital as looking after patients. I am hoping that future editions will manage to catch up and avoid gaps of knowledge as seen

in our recent past and that this edition inspires a new-found enthusiasm for 'getting the job done'. It looks as though I will certainly be looking at a 2016 edition soon to bring us up to date and I will be calling on everyone again to provide this information. I am not sure if I will continue to produce the Reports, but I hope these efforts, the first to be entirely produced in-house, will inspire a greater affinity and association with the publication and mean that it continues from strength to strength.

In designing and editing this book, I have attempted to apply not only my skills as a designer to the job in hand but also much affection, by presenting the information in a clear and readable fashion and illustrating the pages with ample photographs to enliven the experience. I have always been enthusiastic about the social history of the hospital, and make no apology for including many staff portraits. The front cover has been designed in the style of the original annual reports of years gone by, even using an approximate font type for the lettering. The look was also inspired by the cover of the St Mark's Hospital book by Lindsay Granshaw. I have attempted to make this book special not only for me but to those who obtain a copy. I imagine the greatest shame of the modern age is that this will most likely only have a very limited print run and will otherwise be distributed as a PDF, which somehow isn't quite the same as holding the book in your hands. I for one will be making sure I get a printed copy and I'm sure anyone with a long and vested interest with the institution will be keen to do the same.

It has been an honour for me to edit this book for you all, as possibly the first non-medical editor in its long, esteemed history. Fortunately, I seem to have obtained a modicum of medical knowledge from my two decades of exposure to all things St Mark's since joining the institution in 1999. I've had the pleasure of expanding that knowledge whilst quietly filming behind the shoulders of many luminaries such as James Thompson, John Nicholls, Christopher Williams, Peter McDonald, Robin Phillips, John Northover, Sue Clark, Brian Saunders, Simon Gabe, Robin Kennedy, Ian Jenkins and bringing it up to date, Danilo Miskovic. Apologies to anyone I haven't mentioned – the list is too long. For you all, I hope I have done this book justice.

Steve Preston
Multimedia Consultant
Editor

ST MARK'S

HOSPITAL

&

MIC INSTITUTE

St Mark’s Hospital

Clinical Director's Report

Reflecting the national trend, 2014 and 2015 saw an increase in the number of clinics run at St Mark's as well as the number of patients referred. The hospital continues to be both productive and vibrant.

As a result of an increase in activity, we were delighted to see a number of new Consultant appointments.

Joiners

Dr Ashley Barnabas studied Medicine at the University of Natal in Durban, South Africa. He trained in Gastroenterology and General Internal Medicine in the London and South Thames Deanery and undertook specialist training in Liver Disease at the John Radcliffe Hospital, Oxford. He then worked as a clinical research fellow at King's College Hospital Liver Unit, the largest centre for liver disease in the UK. He gained further experience in the management of liver transplant recipients and was involved in a range of clinical trials including those involving all currently available hepatitis C drugs. He also undertook training in hepatobiliary endoscopy during this time. He then worked as a locum consultant in hepatology for a year at King's Liver Unit before being appointed at St Mark's.

His interests in endoscopy include therapeutic upper GI endoscopy and he performs regular endoscopic cholangiography lists. He co-ordinates hepatitis C treatment within the trust and sees a broad range of patients with liver and gastroenterological diseases. He has publications have included in particular 'Primary Sclerosing Cholangitis and the Treatment of Hepatitis C'.

Dr Adam Humphries is a luminal gastroenterologist and specialist endoscopist. He is the clinical lead for endoscopy and his specialist interests include diagnostic and therapeutic endoscopy, bowel cancer screening endoscopy, video capsule endoscopy, double-balloon enteroscopy and inflammatory bowel disease. Dr Humphries also leads the small bowel endoscopy service at St Mark's Hospital, a national referral centre and one of only a few sites in the UK that provides double-

balloon enteroscopy for the diagnosis and treatment of small bowel diseases.

Dr Ian Johnston gained his medical degree from the University of Edinburgh in 2002. He moved to London to continue his medical training and was awarded membership of the Royal College of Physicians in 2005. He performed his Gastroenterology Specialty training in London working at St George's, Hammersmith and St Mark's Hospitals in addition to several District General Hospitals. He completed his training in 2014 and took up his substantive Consultant position at St Mark's in January 2015.

He was awarded his MD by Imperial College London based on research into Bile Acid Diarrhoea. His work has been presented at National and International meetings at which it has been awarded prizes. As part of this research he set up and ran a drug trial, the results of which have been published in peer reviewed journals. He continues to contribute to Bile Acid Diarrhoea and IBD research.

His main clinical interests are Nutrition and Upper GI physiology, including Gastro-Oesophageal Reflux Disease. Other work includes the management of Inflammatory Bowel Disease and Functional GI disorders such as IBS. He performs upper and lower GI endoscopy, oesophageal manometry and pH studies and BRAVO capsule placement and interpretation.

Dr Mani Naghibi gained his medical degree at Guy's, Kings and St Thomas' School of Medicine in London, where he also undertook a second, intercalated, degree in Anatomy and Physiology. While at University he carried out research in the topic of drug delivery to the brain. After university he completed his medical training in the London and Wessex deaneries, specialising in Gastroenterology, Nutrition and General Internal Medicine.

Dr Mani Naghibi undertook his sub-speciality training and research at University Hospital Southampton (UHS), supported by the National Institute of Health Research (NIHR) Biomedical Research Centre for Nutrition. His Medical Doctorate (MD) thesis was based on the use of artificial nutrition for patients with nutrition failure in the context of cancer.

His clinical interests are: supplemental and artificial nutrition, inflammatory bowel conditions, gastrointestinal endoscopy, irritable bowel syndrome, functional bowel disorders, effects of medical treatments on quality of life.

Before commencing his Consultant post at St Mark's Hospital, Dr Mani Naghibi was the Specialist Registrar trainee representative for the British Society of Gastroenterology (BSG) Small Bowel and Nutrition committee, as well as the British Association for Parenteral and Enteral Nutrition (BAPEN). He is currently a committee member for the British Artificial Nutrition Survey (BANS). He continues his research interests into the effects of artificial nutrition in both cancer and non-cancer patients.

What's new?

Congratulations to Dr Claire Taylor who was appointed to the role of MacMillan Nurse Consultant in Colorectal Cancer.

Having completed five years as Dean of St Mark's, Professor Robin Kennedy stepped down. During his tenure there was a considerable growth in the number of courses run as well as the number of visitors to St Mark's. Robin was also instrumental in securing a large grant to upgrade the audio-visual links within the hospital which included live links from theatres and endoscopy to a number of teaching rooms.

Professor Sue Clark took up the mantel and with her strong research background incorporated the research oversight function into the Academic Institute. An Academic Board now meets on a monthly basis to discuss all matters relating to education and research.

Paediatrics

We were delighted that the division of Paediatric gastroenterology became a centre for excellence both for paediatric polyposis and peadiatric inflammatory bowel disease.

Effects of cancer treatment follow-up clinic

Most cancer survivors will not have any long-term lower GI consequences of their cancer or its treatment. However, some will develop problems

including chronic diarrhoea, faecal incontinence, urgency, pain, bleeding and excessive flatulence, particularly following pelvic radiotherapy and surgery. Quality of life can be adversely affected.

St Mark's will offer a specialist multidisciplinary service to help patients with GI problems after pelvic radiation, surgery and chemotherapy. The service will offer a range of treatment options for symptoms such as diarrhoea, incontinence, severe pain and rectal bleeding following urological, gynaecological or bowel cancers.

This service will be led by Dr Ana Wilson (Consultant Gastroenterologist), Dr Siwan Thomas-Gibson (Consultant Gastroenterologist and Endoscopy Lead) and Dr Claire Taylor (Macmillan Nurse Consultant in Colorectal Cancer).

The Heritage Committee

Founded by Frederick Salmon in 1835, St Mark's has a long and interesting heritage. The newly established Heritage Committee is comprised of both current as well as retired staff who, between them, have a vast knowledge about St Mark's Hospital. Whilst an archive already exists at St Bartholomew's Hospital the committee has set about categorising more recent artifacts.

Finally, I must thank all my colleagues for their support over the last couple of years as well as the whole St Mark's Hospital team.

Professor Robin Phillips MB BS MS FRCS
Director & Consultant Colorectal Surgeon

Professor Robin Phillips MB BS MS FRCS
Director & Consultant Colorectal Surgeon

Outpatient clinic with Dr Ailsa Hart and IBD Nurse Specialist Hannah Middleton, 12th March, 2013

Outpatients Department

Nursing Staff

Clinical Nurse Manager (Sister)
Denise Robinson

Staff Nurses
Jocelyn Hyndman
Diane Mattocks
Sarah Pitcher

Health Care Assistants
Kim Connolly
Rekha Thakor
Margaret Adjei-Twun
Suzanne Woodage
Fatima Perwaiz

Clerical Staff

Coordinator
Rosemary Mulcahy

Deputy Coordinator
Timothy Marshall

Clerks
Mayur Pandya
Neerma Shah
Sushila Shah
Claudette Malcolm

It has been a busy year for the outpatient department. The number of clinics has increased and the volume of patients seen has grown. With the increase in nurse-led clinics and patient monitoring the phlebotomy service has reached its full potential and we are regularly bleeding 60–70 patients a day. All nursing staff takes time during the week to cover this important service and they have become experts in this field. Getting blood from quite a few of our patients is a challenge and we have now extended the service to cover some of the more challenging veins throughout St Marks. We have also been able to teach the medical students the art of phlebotomy in the challenging patient.

We have had the opportunity to develop some of the nursing team. HCA Kim Connolly was seconded to the stoma care department and staff nurse Sarah Pitcher to the Macmillan team. There were also learning opportunities for the rest of the nursing team. This included stoma care and the SAGE & THYME® communication course alongside the mandatory training that we all do. These have benefitted the patients and focused the staff to give 'great care'.

Due to the secondment of Kim and Sarah we have been using bank staff to fill these vacancies within the department. We have been fortunate to have regular shifts booked by second and third year student nurses who have enjoyed working with the patients and staff at St Mark's. The increase in the department workload would not have been manageable if it wasn't for the medical records and clerical team working tirelessly to support the clinicians and nursing staff. It is these behind-the-scenes people that really keep the hospital running.

Denise Robinson, Clinical Nurse Manager (sister), OPD St Mark's

Dr Simon Gabe with patient Stephanie Chin, 5th March 2014

Intestinal Failure Unit

Department Leads

Co-Chair & Consultant Gastroenterologist
Dr Simon Gabe
MD, MSc, BSc, MBBS, FRCP

Co-Chair & Consultant Gastroenterologist
Dr Jeremy Nightingale
MD, MBBS, FRCP

Members of Staff

IF Physicians

Consultant Gastroenterologist
Dr Mani Naghibi
MBBS, BSc, MRCP (Gastro)

Consultant Gastroenterologist
Dr Ian Johnston MBChB, MRCP

IF Surgeons

Lead Surgeon for IF
Miss Carolynne Vaizey,
MD, FRCS (Gen), FSC(SA)

IBD & IF Surgeon
Mr Janindra Warusavitarne,
BMED, FRACS, PhD

Specialist nursing

Consultant Nurse Nutrition and Intestinal Failure
Mia Small, MSc, BSc (Hons),
RGN, DipNutr, Rnutr

Clinical Nurse Specialist Nutrition and Intestinal Failure
Sally Crowther, BSc (Hons), RGN

Clinical Nurse Specialist Nutrition and Intestinal Failure
Elaine Trautner, MRes,
BSc (Hons), RN

Clinical Nurse Specialist Nutrition and Intestinal Failure
Patricia Pinnell, EN, RGN

Intestinal Failure Specialist Nurse Practitioner
Sam Drury, MSc, RN,
DipHE Nursing, Ipresc

Intestinal Failure Specialist Nurse Practitioner
Deepa Leelamany, MSc,
BSc (Hons), RN, Ipresc

Dietetics

Highly Specialist & Research Dietitian
Dr Alison Culkin, PhD,
BSc(Hons), RD

Specialist Dietitian
Morag Pearson,
BSc(Hons), RD

Specialist Dietitian
Diane Brundrett,
BSc(Hons), RD

Specialist Dietitian
Beth Rye, MRes,
BSc(Hons), RD

Dietitian
Ellie McKinnon,
BSc (Hons), RD

Pharmacy

Pharmacy Manager
Jackie Eastwood,
BSc (Hons), ClinDip, GPhC

Specialist Pharmacist
Yee Kee Cheung, MPharm,
ClinDip, IPresc, GPhC

Specialist Pharmacist
Deirdre Kriel, MRPharmS,
BPharm, ClinDip, IPresc,
GPhC

Specialist Pharmacist
Bhavisha Shah, MPharm,
ClinDip, GPhC

Specialist Pharmacist
Rasha Salama, BPharm,
ClinDip, GPhC

Specialist Pharmacist
Roshni Patel, MPharmS,
PGDip, GPhC

IF Unit

Ward Manager
Lisa Smith, RN

IF Coordinator
Seema Patel, BSc (Hons)

Consultant Gastro-enterologist
Dr Mani Naghibi, MBBS,
BSc, MRCP (Gastro)

Consultant Gastro-enterologist
Dr Ian Johnston,
MBChB, MRCP

The nationally funded specialist intestinal failure service at St Mark's has continued to grow during 2014 and 2015 – and remains the largest home parenteral nutrition centre in the United Kingdom, currently caring for 327 patients.

During 2014 and 2015 members of the multidisciplinary team were invited speakers at national and international meetings including BAPEN (British Association for Parenteral and Enteral Nutrition) and ESPEN (European Society for Parenteral and Enteral Nutrition). Collectively, the team had 35 refereed conference proceedings (oral or poster) accepted, including five posters of distinction.

There were some notable appointments for a number of the team. Dr Simon Gabe was elected president of BAPEN (British Association for Parenteral and Enteral Nutrition), Dr Jeremy Nightingale was elected chair of BIFA, (British Intestinal Failure Alliance), and Jackie Eastwood was nominated as chair of the national HPN stakeholders committee.

The team also continue to be actively involved in national specialist groups including the BPNG (British Pharmaceutical Nutrition Group), NNNG (National Nutrition Nurses Group), PENG (Parenteral and Enteral Nutrition Group) and the gastroenterology specialist group (GSP) of the British Dietetic Association.

In 2014, Mia Small was awarded third place in the British Journal of Nursing Nutrition Nurse of the Year awards, and Beth Rye won BAPEN student of the year for her MRes project. In 2015 Dr Alison Culkin was awarded best poster presentation at the DDF (Digestive Diseases Federation) conference.

The St Mark's Intestinal Failure and Home Parenteral Nutrition course which has run since 1998 continues to prove popular and attracts more than one hundred delegates a year from all over the country as well as internationally. In 2015 Dr Simon Gabe and Dr Alison Culkin were invited by AusPEN (Australian Parenteral and Enteral Nutrition Society) to deliver a two day IF course in Sydney.

Novel and new interventions

- Introduction of 70% isopropyl alcohol port protectors which has seen a dramatic reduction in central venous catheter related sepsis (1.3 per 1000 catheter days to 0.4 per 1000 catheter days).
- Remote real-time monitoring of HPN patients using GPRS technology which has allowed early identification of catheter and infusion-related problems.
- Introduction of an electronic patient held health record which enables patients to manage their care and help clinicians share information and engage with patients.
- Introduction of IF nurse practitioner led PICC (peripherally inserted central catheter) insertion service.

Key publications

Pironi L, Arends J, Baxter J, Bozzetti F, Peláez RB, Cuerda C, Forbes A, Gabe S, Gillanders L, Holst M, Jeppesen PB, Joly F, Kelly D, Klek S, Irtun Ø, Olde Damink SW, Panisic M, Rasmussen HH, Staun M, Szczepanek K, Van Gossum A, Wanten G, Schneider SM, Shaffer J; Home Artificial Nutrition & Chronic Intestinal Failure; Acute Intestinal Failure Special Interest Groups of ESPEN. ESPEN endorsed recommendations. Definition and classification of intestinal failure in adults. Clin Nutr. 2015 Apr;34(2):171-80

Funding

- Edith Murphy Trust, £50,000 (intestinal tissue engineering).
- Rosetree Foundation, £98,000 (intestinal tissue engineering).
- St Mark's Hospital Foundation £3,300 (assessing the impact of home parenteral nutrition on sleep duration and quality: a proof of concept study).

Top: Foundation staff 4th August 2014: L–R: Stephanie Van Der Wens, Riyah Talati, Anthony Cummings, Shelina Ali, Alex Burton. Below: The Foundation accepts a legacy donation, 20th July 2015

St Mark's Hospital Foundation

Chairman Of Trustees
Michael Liebreich

Trustees
Prof Robin Phillips MB BS MS FRCS
Dr Michele Marshall BSc MRCP FRCR
Catherine Boardman
Margaret Burgess
Robin Kennedy MS MBBS FRCS
Paul Bouscarle
From September 7th 2015
Sharad Rathke
From December 8th 2015
Christine Norton To June 2014
William Phillips To December 2014

Executive Director
Anthony Cummings BA MBA

Dean
Sue Clark MB BCHir MD FRCS (Gen Surg)
EBSQ (Coloproctology)

Operating Director
Judith Landgrebe BA MSc

Accountant
Maia Phutkaradze
From December 2014
Alan Wraight
To November 2014

Trusts And Foundations Fundraising Manager
Ms Riyah Talati BA(Hons)

Multimedia Consultant
Medical Photographer
Video Director/Producer
Stephen Preston BA(Hons)

Senior Fundraising Executive
Alexander Burton
From March 2014

Website And Digital Content Coordinator
Hannah Glen BA(Hons)
From December 2nd 2013

Fundraising Executive
Stephanie Van Der Wens
From March 2014 To Nov. 2015

Finance And Administrative Executive
Deema Ramgoolam
From November 2014
Zeenat Penkar
To December 2014

Fundraising Administrator
Shelina Ali
From March 2014 To Sept. 2015
Ruth Wales *To March 2014*

The St Mark's Hospital Foundation achieved its best financial performance in its near 20-year history, with overall income for the year rising to over £2 million, with £1.7 million received from fundraising activity and voluntary contributions from grateful patients, major donors, trusts and foundations and bequests in wills. Fundraising income increased by 97% compared with the previous year.

A strategy of forming strong on-going partnerships based on the provision of larger research projects to loyal supporters saw a large

number of multi year commitments, leading to the carry-over income secured for future years being in excess of £300,000.

A major development over the 2014 and 2015 financial years was the concerted focus and efforts by the Board, professional staff of the Foundation working with the medical staff to develop a new strategy for the development of 'St Mark's Institute', a new Centre of Excellence for St Mark's research, education and development of clinical best practice activities. This new strategy, which consists of developing six Centres of Excellence that cover such areas as Advanced Cancer, Minimally Invasive Therapies and IBD research within the overall St Mark's Institute, will feature strongly in future years.

The following points give a flavour of the high level of activity of the Foundation in 2014 and 2015:

- Continued to develop strong working relationships between the Foundation fundraising team and medical consultants, which extended to research fellows, nurses and support staff.
- Produced a new legacy brochure, which was supported by a national and local legacy campaign.
- Maintained a constant output of quality applications to leading Trusts and Foundations.
- Held a major supporters' dinner at the Victoria & Albert Museum attended by over 300 supporters.
- Account managed and substantially supported several key fundraising groups.
- Supported over 60 individual fundraisers and 12 groups to raise funds.
- Substantially increased our press and PR activity securing national and local coverage in printed and digital platforms.
- Supported a large number of challenge event participants in a range of different events.

Anthony Cummings
Executive Director, St Mark's Hospital Foundation

Support Groups

Friends of St Mark's

President
James Thomson

Vice President
John White

Chairman
Gillian Rodrigues
From April 2015
Robert Azevedo-Gilbert
To March 2015

Vice-Chairman
Elaine Grant

Honorary Treasurer
Alan Wraight
From October 2014
Martin Palmer
To September 2014

Honorary Secretary
Helen Shorter

Committee
Annie Driscoll
Janet Hammersley
Saroj Kale
Alan Oldham
Jenny Thompson
Gillian Whitmee
Solveig Wilson

The Friends have funded the mounting of a new artwork display for the corridors from the University of Westminster's Art Department and the former Chairman spent many hours installing the paintings. We also provide free wi-fi for patients on the Frederick Salmon Ward, the John Lennard-Jones Intestinal Failure Unit and the IBD dayroom. Long-stay younger patients particularly appreciate the internet access.

We also participated in Bowel Cancer Awareness Month in April 2014 by displaying information and the giant bowel tunnel in Harrow town centre, along with a novel balloon race.

We have continued to support individual patients with grants towards travel and accommodation costs for them and their families and to maintain equipment and provide supplies for the patients' laundry room on the Frederick Salmon Ward, a boon for long-stay patients who are a long way from home.

Christmas gifts for inpatients are a standard feature of the Friends' expenditure and a Father Christmas has been known to deliver them in person, with the help of the former Chairman.

A tireless Friends' volunteer regularly refreshes the magazines in the waiting areas, whilst other volunteers help in the Tea Bar, from which the Friends receive a share of the profits.

The small garden at the main entrance is maintained by the Friends to provide a quiet space for patients, visitors and staff.

Funds have been raised through donations, often received in response to our biannual newsletter to members. A raffle, bric-a-brac and cake sale at the annual 'Birthday Party' and ad hoc homemade cake sales throughout the year also add to the coffers.

The Friends' President James PS Thomson presenting a hospital history lecture at the Association Day conference on the 175th anniversary of St Mark's Hospital in 2010

Inside-Out Stoma Support Group

Inside Out have provided throughout the years stability, knowledge and support to all stoma patients no matter if they had their stoma's performed here at St Mark's Hospital or elsewhere in the county. Through our newsletters, web-site and coffee mornings and under the chair ship of Martin Morris and the committee.

We have supported the training of new up and coming surgeons by being part of their exam procedure, we are involved in training new GPs at one of the surgery's training centres for Imperial College in Harrow. We are involved in research projects both in St Mark's and at the Royal College of Surgeons, (Delphi Games), in London. We have helped to change the outlook on how stoma's are perceived, not as a negative but as a positive way of having a better quality of life, to enable us to take those first little steps that can be the most challenging in the beginning.

Inside Out is looking forward to the future, the changing faces of how the NHS moves into the 21st Century and how as a patients support group can be part of those changes especially to the patients and their families.

Robert Lopes de Azevedo-Gilbert
Cofounder & President of Inside-Out
iossg.org.uk

Dr Ailsa Hart with Chang-Ho Ryan Choi BSc, MSc, PhD, 12th March 2013

St Mark’s Academic Institute

Dean's Report

Dean
Professor Sue Clark

Sub Dean
Dr Ailsa Hart

Director Of Research
Mr Omar Faiz

Director Of Education
Dr Siwan Thomas-Gibson

Departmental Manager
Judith Landgrebe

Course Manager
Janice Ferrari

Multimedia Consultant
Stephen Preston

Assistant Course Manager
Rasmita Bhudia

Development Manager
Hannah Glen

Administrative Assistant
Pam Nye

Volunteers
Marty Morris
Bharat Shah
Ratan Vatcha

I was hugely honoured to succeed Robin Kennedy as Dean in January 2014. He had completed five highly successful years in the role, and has been a hard act to follow!

The Academic Institute has taken on a role in the oversight of research at St Mark's, with the Education Executive reverting back to the Academic Board, as it was some years ago. We have started the collection of our research metrics and refurbished the research fellow's room. Monthly research forums provide generic training applicable to research, as well as giving fellows the opportunity to present research plans and rehearse oral presentations in front of a friendly but critical audience.

We have continued to run postgraduate teaching terms, with an extra, shortened, programme each summer for a group of surgeons from China. Our programme has expanded and evolved, with a number of new courses being introduced. We continue to host over 1,500 visitors, for anything from a day to a year, as observers and clinical assistants. Most are from overseas, and all contribute to the richness of the community of St Mark's.

Some of our overseas links have been strengthened by a new initiative,

Professor Sue Clark
MB BCHir MD FRCS (Gen Surg) EBSQ (Coloproctology), Consultant Colorectal Surgeon

'St Mark's International'. Teams of speakers from the Hospital have been invited to contribute whole sessions to overseas meetings which have taken place in Salzburg, Saudi Arabia and Croatia.

The 'Frontiers' meetings in 2014 and 2015 have built on previous years, filled to capacity, and running in profit. Our visiting Professors (Finlay Macrae and Dion Morton in 2014 and David Rubin and Willem Bemelman in 2015) have all made memorable contributions.

The first 'John Nicholls Prize' for the best presentation by one of our research fellows was awarded to Nuha Yassin in 2014 followed by Ryan Choi in 2015. This event takes place during the Frontiers meeting with our eminent Visiting Professors judging the competition.

With a large grant secured by the St Mark's Hospital Foundation, the audio visual system was completely upgraded. High definition images can now be streamed live from theatres and endoscopy to three separate auditoriums. The image quality and sound are superb and this addition has enabled the expansion of our teaching repertoire.

Finally I am delighted to report that both the St Mark's Hospital and the St Mark's Academic Institute websites have been updated and made more user friendly. The former focuses on patients and the information they may need when coming to hospital. The Academic Institute site will tell you all you need to know about the 35 courses we run and how you can come and study with us.

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Photographs from The Hospital Foundation Gala Dinner 2014

Victoria & Albert Museum, October 23rd, 2014

Photographs from The Hospital Foundation Gala Dinner 2015

Kensington Palace, June 4th, 2015

Top: Prof. Ailsa Hart with research students Chang-Ho Ryan Choi, Nuha Yassin and
Below: Prof. Hart with Nuha Yassin MBChB, MRCS, MSc, 12th March 2013

St Mark's Multimedia

Department of video production, graphic design, medical photography and publishing

In 2014, there were two major DVD/HD releases from Professor Robin Kennedy, Anterior Resection of Rectum with TME (Sala, Jenkins, Kennedy) and Laparoscopic Segmental Left Colectomy (Uraiqat, Jenkins, Kennedy).

Several surgical films were produced including Sciatic Notch tumour Surgery (Jenkins), First human Eversion FLEX Procedure (Suzuki, Thomas-Gibson, Kennedy); Patient Recovery Interviews (Claire Taylor); Perineal Sinus Excision with Coloplastics (David Ross, Omar Faiz); Fistula repair (Warusavitarne, Vaizey). A special series of films was commissioned to record fellows experiences at the hospital, called My Time at St Mark's (Ahmad Uraiqat, Nuha Yassin and Omer Aziz).

Anthony Cummings of the St Mark's Foundation requested photographing staff portraits, department photographs and staff at work. The Foundation Gala Dinner event was photographed. The retired staff gallery on Level 5 had a new entry this year as Christine Norton was departing. This was also the year of the Polyposis Department's 90th anniversary, where the cutting of the cake was recorded for posterity. Surgical photography was in evidence again, such as a Sacrectomy case for Anthony Antoniou, showing unprecedented detail for a presentation he had in mind.

Design continued to be a much in demand service, with posters and brochures being called for, such as the Safe Endoscopy Teams in Bowel Cancer Screening (ENTS) booklet (Manmeet Matheroo). A new lecture was developed this year for students and postgraduates entitled Designing Successful Posters, aiming to improve the academic output. Hannah Glen requested design work and photography for the new St Mark's website, such as the icons, graphics and photography you see around the site. This year, Professor Brian Saunders requested the design of The Christopher Williams Lecture 2015 award, given to Douglas Rex at Endolive 2015.

In 2015, a series of videos, photographs and graphics for Endoscopy Techniques (Siwan Thomas-Gibson, Adam Humphries, Arun Rajendran) and a film of Laparoscopy assisted endoscopic adhesions removal (Brian Saunders, Zacharias Tsiamoulos, Janindra Warusavitarne) was produced. There were also Ileo-Anal Pouch Single Port Surgery (Louis Vitone, Alex Leo, Janindra Warusavitarne), Laparoscopic single port TME (Alex Leo, Janindra Warusavitarne), Peutz-Jeghers Syndrome Endosurgery (Janindra Warusavitarne, Adam Humphries), Laparoscopic Pelvic Exenteration (Ahmad Uraiqat, Irshad Shaikh, Ian Jenkins) and a Sciatic Notch ELSiE Video Edit (Ian Jenkins). Kapil Sahnan's research into 3D visualisation of Crohn's perianal fistula was also supported by the department, producing graphics, videos and presentation materials.

Promotional photography for Anthony Cummings, the Executive Director of the St Mark's Hospital Foundation, continued with the NPIMR donor visit and the Foundation Gala Dinner at Kensington Palace, and further staff photography for teams such as the Foundation Team, the Biofeedback team (Brigitte Collins), the Bowel Cancer Screening Team and Administration Team and the Physiology Department (Jennifer Haynes). Surgical photography continued, producing detailed work for Exenteration Ileal conduit (Ian Jenkins), Massive Hernia (Louis Vitone, Carolynne Vaizey), Enterocutaneous Fistula gastrointestinal surgery abdominal open wound (Carolynne Vaizey).

A presentation was produced this year to help support the charitable bid for funds with Fidelity. We received a substantial sum from the organisation (Anthony Cummings, Riyah Talati, Sue Clark).

An action group for St Mark's Heritage was established (Ian Jenkins,

Max Pitcher, James Thomson, John Northover). It was apparent that we did not have a good historical record of the hospital since the move from City Road, and was in fact rather scant from the 1980s when the book St Mark's Hospital, London: A Social History of a Specialist Hospital was published, detailing the period up until that time. We had several meetings looking at the areas currently lacking and paid a visit to Barts, where the existing St Mark's archive is housed. There was renewed enthusiasm and pressure to restart the Annual Report. I began to collect heritage items that would have otherwise been thrown away, and now have a significant archive on site, including records, photographs and artefacts, although they are not organised or annotated in any proper fashion. A requested was made to move the lunch table at Vernon's café away from the painting of William Taylor Copeland as there was an increasing amount of damage to the frame from the café's customers. The current situation of chairs facing away from the painting is still not ideal, but gives us some time to make a decision on the painting's future.

Filming ileo-anal pouch single port surgery
with Louis Vitone, Alex Leo (not pictured), Janindra Warusavitarne, 27th March 2015

The talk on Designing Successful Posters was given again and a further talk added on Making a Successful Presentation for the students and postgraduates, which was well received.

This year saw the beginning of a new venture into publishing, with a book entitled Ileo-Anal Pouch Surgery for Ulcerative Colitis written by Zarah Perry-Woodford (Sue Clark). In order to produce the book in-house, new skills were developed in professional book layout, graphic design, illustration and photography for books and the copy-editing of the complete manuscript. We worked closely with the printers to make sure the work met the exacting specifications required.

Several meetings were attended with Judith Landgrebe, Duncan Say, Alistair Holdoway (Video South) and Robin Kennedy concerning the development of the new Theatre 6 and Theatre 11, working with the team on the installation of media equipment and networking to lecture rooms.

Graphics-wise it was another busy year, producing images for various publications such as High Subcortical Sacrectomy HiSS (Irshad Shaikh, Ian Jenkins), Posters for various staff members including complete sets for Zacharias Tsiamoulos, Manmeet Matharoo and Siwan Thomas-Gibson, plus brochures and programmes such as Bowel management for continence advisors programme (Brigitte Collins).

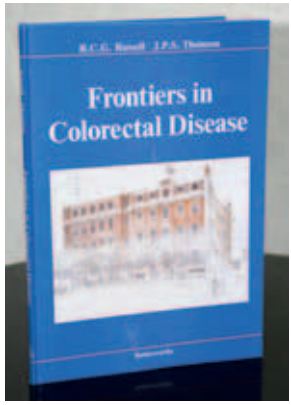
This year we also moved forward on setting up the Digital Media Archive Server (Judith Landgrebe) for postgraduates, students and staff which would replace the existing videotape library housed on Level 5. The process of collating materials and cataloguing assets is ongoing.

Stephen Preston
Multimedia Consultant

The Heritage Committee

Committee members Ian Jenkins, Stephen Preston, John Northover, James PS Thomson

Whilst working in the media department, I've often come across interesting archival material which has significance in telling the story of St Mark's. Most of these items were heading for the bin and in fact I have often found things actually in the bin!



The media has taken the forms of 16mm film reels, old VHS cassettes, Beta tape transfers, old photographs of staff, events, buildings and departments, online historical records research, photographic archive research, old slide collections, old presentations from the 1990s, historical artefacts such as vases and plates, and record books of meetings going back decades.

Amongst these many items I have collected are the paperwork for the opening of the Wolfson Unit for Endoscopy in the 1990s, a large paper record and plans for the new outpatients department at Northwick Park, the minutes book for the St Mark's Association from its inception in 1967, a book detailing the postgraduates and visitors from 1946 and over the next twenty years, the 1986 Frontiers Annual hardback celebrating 150 years, produced by RCG Russell and JPS Thomson, a Pathological Records book starting in September 1925 and continuing for hundreds of pages over the next five years, a large collection of ink artwork diagrams for surgical presentations long before the advent of

computers and Photoshop and many more significant finds.

In 2010, Professor John Northover brought to my attention the collection of surgical films from the 1930s–1970s, the only known copies of which being on the Beta tapes in the postgraduate room. In addition, he passed on to me a small 8mm film reel of the retirement of ETC Milligan on the 23rd June 1951, filmed around City Road and on the hospital roof top, featuring several notable surgeons of the time, shot on colour film no less! It was during this time that we realised we both held an interest in all things historical, and it wasn't long before James PS Thomson joined the informal talks, particularly when obscure facts were sought after. It was this small group that eventually led to the production of the film St Mark's at City Road, which I produced for the hospital.

We formalised the group under the banner The Heritage Group and we were joined by Mr Ian Jenkins who would represent the hospital in it current form, with both Thomson and Northover now retired. The intention was to seek funding, with the help of Barts, to help progress the

The William Taylor Copeland painting, originally housed at City Road but now next to the cafe area in St Mark's. The tables next to the painting resulted in the frame being vandalised (right).

current state of the archive in central London and perhaps to curate the new material so far gathered and perhaps begin to research the record for the hospital between the mid-1980s and the present day.

The St Mark's Collection at the Barts Archive

It came to our attention that a great number of documents, publications and photographs were being held at Barts in central London, but that a large proportion of information, particularly the later period, was disorganised and uncategorised. There were other concerns too. In particular we were worried about the growing damage to the William Taylor Copeland painting next to the cafe near the St Mark's entrance. Some years prior, a cafe table was placed next to the painting and unfortunately over time, visitors have damaged the frame by removing chunks of alabaster leaving several unattractive patches. An opportunity arose to apply for internal funding in 2015 and we obtained a small grant which is still awaiting action, the application of which listed several areas of interest, including technical gear to archive materials in-house.

In-patients records from 1930 with the names of prominent surgeons Lockhart-Mummery, Gabriel, Gordon-Watson and Milligan decorating the spines. (The Barts archive in central London).

Various other avenues were investigated and the WELLCOME Trust was approached with a formal application – we were initially unsuccessful but we now have a fully funded Archivist working through our collection, a terrific achievement for The Heritage Committee and Kate Jarman, the Senior Archivist at Barts.

The City Road site

It was during this period that an old postcard of St Mark's on City Road was uncovered from the turn of the century and we were all interested to see the edge of the next door building appearing in the photograph, The Independent Chapel. It was whilst trying to uncover more information about the buildings that surrounded or occupied the site that some interesting facts were uncovered. The original City Road site before the hospital was built was occupied by the Orphan Working School to the left (where the Independent Chapel stood later, now demolished), The Dyers' Almshouses for the poor was positioned centrally on the main foundation site of St Mark's, and to the right was Halls Paper Hanging Manufactory. What is remarkable is two paintings have been discovered showing the original street scene prior to the building of St Mark's, showing both the orphanage and the almshouses.

If you look at the map of the area today, you will see two streets adjoining City Road either side of the former St Mark's, that of Pickard Street and Hall Street, Hall being a connection with the paper hanging warehouse of the same name, and Rev. Dr Edward Pickard (1714–1778) was the founder of the orphanage, originally in Hoxton, but then relocating to City Road at these purpose-built premises where more than 80 children could be housed.

Professor John Northover's retirement

Professor Northover retired on May 31st, 2012, but without an Annual Report to mark the occasion, I have decided to reproduce the content of a booklet we published as part of the release of a special blu-ray/DVD video to mark his retirement. It was entitled 'A Finishing Note'. Here is the text in full:

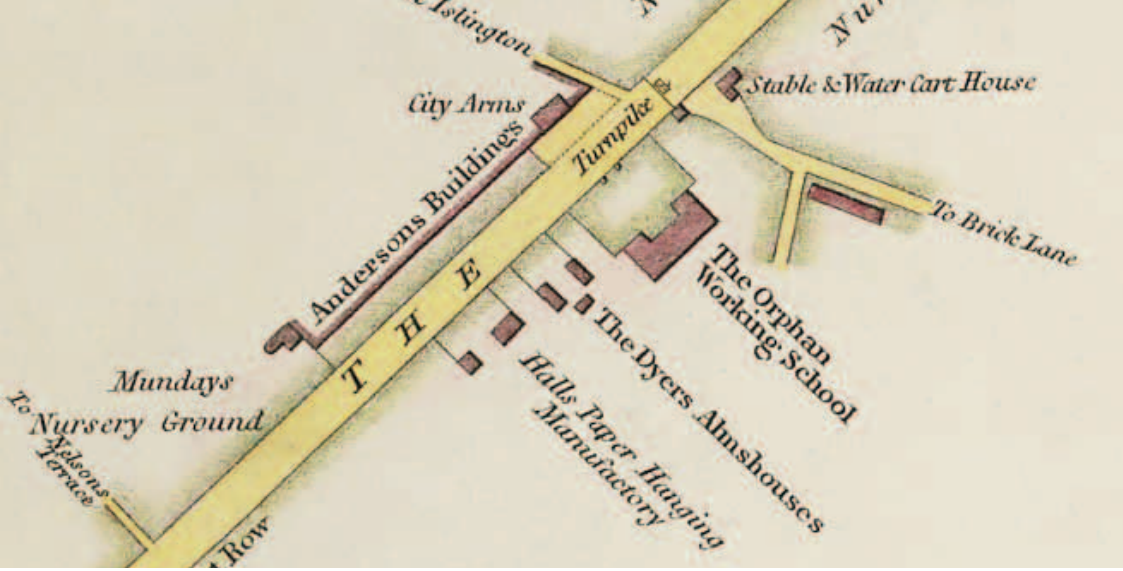
In the run-up to it I spent a lot of time thinking about my departure from St Mark's. It was difficult to imagine simply not being there, and shedding the 24/7 NHS responsibilities

View of the school building, on City Road, north London; a roller on lawn in foreground, two couples walking in front garden; illustration to the 'Congregational Magazine'. 1826

The Dyers' almshouses on City Road, taken down in 1851. "The central building set back from the road with two wings flanking forecourt; a woman passes through iron gate to street, other figures on pavement, including running children and a man riding a horse on street." Held at the British Museum. The inscription below mentions St Mark's is under construction.

A postcard of a scene from the operating theatre at St Mark's Hospital, City Road, the date is unknown though the card is in the same format as the exterior photograph below which is late 1890s or the early 1900s, as the church next door was demolished before the onset of the Great War. This would make it the earliest known photograph of hospital staff at work.

A postcard showing St Mark's Hospital on City Road sometime around 1900. To the left you can observe the Independent Chapel, demolished in the early part of the 20th Century, this being the only known photograph of the building. To the rear, low level housing and businesses.



A London map showing City Road in 1809, featuring Halls Paper Hanging Manufactory, the Dyers' Almshouses and the Orphan Working School. St Mark's was built on the almshouses' site.

I felt I had borne since leaving medical school more that 40 years ago. Towards the end I just wanted to get it over with and move on. I found myself inventing computer passwords that marked the denouement (I forget them frequently, and so have to make up new ones with irritating regularity) - variations on: 'retiring[date]', 'almostthere[date]', threedaystogo[date]'. I will always be grateful for all that my career has given me: there have been many marvellously uplifting experiences but also some heart-rending tragedies to live through and beyond. Now there was something natural and rounded about my impending finale: it was simply meant to be. The day that I chose for my exit was the last day of May 2012, a Thursday, and therefore my weekly operating day. I sought to go out with a flourish - the idea of wandering limply away after an outpatient clinic, let alone on a day with no clinical activity, was unthinkable. Furthermore, there was no way that my final list would conform to the traditional model - a safe string of EUAs or benign and predictable anal forays laid on to allow the retirer to engage more fully with the past and present colleagues and friends who visit theatre to 'be there' at the end. I wanted to do something more memorable, preferably a single case that might characterise my particular surgical practice.

Providence interceded - a couple of months earlier the ENT surgeons had asked me to see a patient of theirs with a lump on his buttock. Once I had met the patient and beheld the magnificent excrescence - a lump a full foot across that he had lugged around for eight years – at last I knew the name of the patient (DS) who would see me out of the National Health Service. The NHS and JMAN had run their course together since they were born within a year of each other; but soon they were to go their separate ways, and resection of this extraordinary lesion was to mark that parting.

When I first met DS I had asked what finally made him want to be rid of this tumour. It turned out that it was not just to be relieved of his heavy burden - mainly it was because he was fed up with his grandchildren poking at it and asking what it was. Fair enough.

It was most likely that it would turn out to be benign having been there for so long and with no scan evidence of malignant invasion. The imaging had shown that much of the tumour had been replaced by calcium deposits: effectively it was a boulder clinging inanimately yet intimately to his behind. Moreover we could see on CT scan that it had a tremendous blood supply so, seeking to avoid major haemorrhage (not during this case, on this day, please not!) we sought help to decrease the risk. So on the morning of surgery our inspired interventional radiologist, Yaser Naji, carried out a procedure to obstruct its blood supply by delivering into the arteries feeding the tumour multiple tiny thrombogenic coils through a catheter manoeuvred into the patient's pelvis via his groin.

Fitting the operation into that last afternoon was going to be tight, and I certainly didn't want it to drag on into the evening, by which time the assembled crowd would have dwindled anticlimactically, perhaps to nobody. So I was there on time, and I had asked all involved that we try to get 'knife-to-skin' promptly at one o'clock. Poignantly, before he was anaesthetised DS gave me a card wishing me well in the times beyond that day.

There was a good turnout - fellow surgeons (including John Nicholls who had gone through the same ritual seven years before), many theatre staff, anaesthetists, surgical trainees, international visitors - and other colleagues who had ventured outside their familiar habitats: physicians, pathologists, psychiatrists, endoscopists, radiologists. Everything was being filmed and photographed comprehensively by our resident audiovisual guru, Steve Preston. He was hard at it even while anaesthesia was being induced, in the lull before any possible storm; first he shot the whole assembly, and then a series of self-assembled sub-groups, everyone there to show solidarity with the leaver.

The tumour appeared even bigger on the table than before, resembling nothing more than a hydrocephalic, varicose, bald man trying to break out of another man's buttock. It had made buying trousers a challenge for years, but that was all about to change. The surgical team comprised myself, my juniors, Ian Jenkins (who will take over my complex cancer practice), and my fine friend, David Ross, senior plastic surgeon at St Thomas's Hospital, a regular member of our multispecialty team.

As always, we surgeons enjoyed working together that ultimate afternoon. Each played his full part, working carefully to separate this monster from its host. It went like a dream, and we were relieved to find that Yaser's work had paid off. Whilst concentrating on our task we were nevertheless able to keep up a convivial banter with our visitors as befitted

the occasion. As we came close to completion my colleagues insisted that I make the coup de grace. As I lifted the boulder aloft, in an instant the patient's weight fell from 18 stone to 17, and the audience sportingly applauded this last act of my NHS career. Finally David Ross removed the excess skin (the tumour had stretched it so much) and closed the wound cosmetically. We were done.

A clockwork exercise had taken two and a half hours. When Krysia Konieczko, my long standing, long suffering and greatly valued anaesthetist, had awakened DS we told him that his operation had gone well and that finally he was freed of his encumbrance.

Just as I had wanted my final operation to be symbolic, I had decided many months ago that I would not leave St Mark's by simply getting into my car and driving away, as I had done on countless anonymous occasions in years past. No, there had to be a challenge here also: I had decided that I was going to walk the ten miles home - a rite of passage, a time for solitary reflection, and an act so supremely contrary to my lifelong 'non-athleticism' that it would help me to draw a line from which I would move on.

Late last year my children had told me, gently but resolutely, that I needed to start taking regular exercise (Tom was the short-straw bearer of the message); so a month or two after delivery of that edict, my newly hatched and manifestly over-ambitious plan seemed to fit in well. When in January I told Tom and the others about the walk they were suitably surprised and impressed! As a confirmed gizmophile I was happy to have an excuse to splash out on items to aid my preparation for the walk; I acquired an intimidating treadmill and I re-instituted the Royal Canadian Air Force Exercise Program (lasted attempted during a mid life crisis 25 years ago); also I bought a posh pedometer to record my every step, every metre walked, for the foreseeable future. Soon I was walking regularly on the machine (nothing would induce me to run!), and by April I was getting up to the ten miles I would have to manage if I were to get home successfully from St Mark's. By that time I had lost a stone and a half (even more than DS was to lose when we edited his waist measurement some months later), though the rate of descent was beginning to flag. In early May, like a giant fledgling leaving the nest, resplendent in my new sheer-fit black Lycra plumage and sporting a brand new hi-tech GPS watch to track my every athletic move for later download, mapping and critical analysis, I began a series of weekly ten mile outdoor walks early on Sunday mornings, when the world is devoid of humanity and the air is bracing.

By the designated day I had six 10 milers, indoor or out, under my belt and I was raring to go. If there was to be any hesitation in exiting St Mark's on that final afternoon, the pull of the walk would give some counter traction: to leave was to set off on an adventure, to enter a new and unmapped phase.

Top left: last day at school. Top right: early days as a St Mark's consultant.
Bottom left: a surgeon in training (2012). Bottom right: portrait taken 14th November, 2012.

As we finished the operation my friends and colleagues melted quietly away – they all knew that 'the walk' had to be a solitary affair though at one stage they had threatened to ambush me outside every pub along the way. And so I found myself climbing alone to the changing room with no difficult goodbyes to negotiate. I took off my "raspberry" pyjamas (NHS speak: just dark red, really) and my boots – no longer the pristine white of 1995, the year we all moved to Northwick Park, but yellowed through long service, with blackened traces of blood from countless patients ingrained into the crannies between the uppers and the soles. I had washed my final pair of gloves and had kept my cap and mask. I put them all in my locker to give later to my children – two boots, a shirt and trousers, and the 'accessories', a convenient five heirlooms.

I walked slowly back to my office where I shed my day clothes and donned the now familiar walking kit - the phoenix was rising. In my back pack were a litre of "Lucozade Sport – Isotonic Performance Fuel" (terrific stuff) and a hip flask acquired for the occasion, filled with a whisky that had set me back a three digit sum. Now I was ready to face the world. Slowly I ambled out, and waited in the car park for a couple of minutes while my gizmo-orgasmic GPS watch located the necessary gaggle of satellites. And then I was into it, marching anticlockwise around the left anterolateral quadrant of the perimeter road. As I left the campus there was a heaviness in my chest, leaving behind my decades in the National Health Service, wondering what might lie ahead.

Now it was time to tackle those ten miles. No longer were they the supreme challenge of six months before, though a challenge they remained: but at least I knew I had a sporting chance of getting home without ignominious recourse to my Freedom Pass.

I had chosen the route as the shortest option according to my iPad. Being unfamiliar territory, I had driven it a couple of times in the hope of not getting lost on the day, but I had studiously stayed away during walking practice. From Northwick Park it went through Kenton and Kingsbury, meandering on east, ultimately passing under the M1 and crossing the A41. From there it was uphill to Hendon before turning left for the long walk down to the A1. Then came the protracted climb to Finchley Central where I would join the busy Finchley Road, striking north east to Tally Ho Corner. And so into the final easterly leg, the straight run (walk!) to Friern Barnet and the erstwhile Middlesex County Pauper Lunatic Asylum, now a born-again and grand apartment complex, my place of abode.

I have minimal recollection of my thoughts during much of the walk. I certainly did not find my life flashing before me as if I were drowning: looking back it was more karma than calamity. As always when walking like this, I found myself looking at and into all the diverse places where people live and work, and wondering what they make of their lives.

There was just one happening en route, three quarters of the way through my increasingly inexorable progression. As I was tackling the long climb from the A1 towards Finchley Central a car drew up and a woman stuck her head out; I thought she was going to ask me for directions, so I was preparing to disappoint her. Then I realised it was Madeleine Cohen, wife of Richard, a one-time St Mark's colleague, one of 'the six' tempted away to University College Hospital some years ago; a glance beyond her confirmed Richard at the wheel. They were clearly bemused to be confronted unexpectedly by someone they would never have dreamt in a month of Sundays might materialise before them dressed in skin-tight black apparel, sporting a go-faster aerodynamic backpack. Richard found my explanation unconvincing: I could see he thought I had completely lost my marbles. It was only after three failed attempts to have me accept a lift – imagine! - that he gave up and drove away, leaving me to power on up the remainder of that long and unforgiving hill.

Arriving home I felt that I had well and truly left St Mark's behind: the passage of which the walk was the rite had been negotiated successfully. Notwithstanding, I was due back at St Mark's at noon the very next day for a farewell lunch. So when I sent an immediate text to 35 colleagues announcing the completion of my mission I included the following plea:

> ***To those that will be at tomorrow's bash, I say this to you: please avoid being remotely nice to me - I will not be able to survive the emotional challenge. Seriously. And so to the shower.***

And so, indeed, to the shower, followed by some food, and finally, after emptying what was left in the hip flask, to bed.

I woke around seven the next morning, the previous day feeling an age ago. Around 7.25 Lindsay called suggesting breakfast. Seemed a good idea, a chance to debrief on the day before and to talk through the upcoming ordeal of the goodbye buffet lunch. We met at Carluccio's in Muswell Hill at nine, just as the MDT was getting under way – life moves on. Discussion of the before and the after was therapeutic, and when my uova e funghi and her fruit salad were finished, Lindsay took me to Finsbury Park Tube. Her perceptive but manifestly powerless advice "not to get teary" did not help to diminish the dread of losing it at le moment critique - at several such previous events I have witnessed more robust individuals than me 'losing it', so I was aware that I might be riding for a fall despite the successful day before.

It was between Baker Street and Finchley Road that I suddenly had the answer to the control bit. Everyone speaking at their leaving do seems to get into maudlin mode –

"What a privilege it's been to work here", "This isn't really goodbye", "The dear old place will go from strength to strength", "When I think of all the patients . . ." (very dangerous territory, control-wise, I noted several years ago), "Oh yes – I have lots to do in the future, travelling, reading, gardening". All very predictable and lame, even if heartfelt: and all grist for the crack-up. So I decided that I would avoid all that stuff completely. Instead, with playful and spontaneous humour I would recount the story of the day before (the majority at the lunch would not have been in theatre, and NONE was on the walk) – how we chose the patient for the final list, how the operation went, how the rite of passage was conceived, the training, the walk itself, the Cohen incident – anything and everything except how sad I was to be leaving. Suddenly I was looking forward to it, perfectly at ease and confident that I would not embarrass myself and those around me.

It turned out to be a truly joyous occasion - many old friends had come back to join colleagues from all disciplines around St Mark's. There were two spectacular cakes, one topped by a tableau of surgeon and patient in theatre; it had been made by a hospital volunteer, and the first of many photographs obviously had to be of le gâteau, la patissiére et moi. Everyone was very happy, and there were many more pictures – as in theatre, groups stepped forward spontaneously to contribute to the record of the occasion.

And on to the inevitable speeches and presentations. Robin Phillips gave the Headmaster's Report on the departing Head Boy, and then presented gifts from the hospital. First, and most astutely, my colleagues had clubbed together to send me on a four day trout fishing course in Devon, brilliant idea as I had taken my brother (both of us novices) to the River Tay to try our hands at salmon fishing to mark his 60th birthday last year. It wouldn't have been the same if I had not then received the obligatory St Mark's tea towel, tee shirt and coaster, rounded off by my long service badge (given to everyone, from cleaner to colorectal surgeon, leaving after five years of service). And there was also a book bound in white leather containing messages from a myriad of colleagues, trainees, people from every corner of St Mark's – one of my longest serving patients had inscribed a page. Then my anaesthetist, Krysia, stepped forward to recall our times together since the move to Northwick Park 17 years ago, through thick and thin, the triumphs and the disasters. Thursdays without Krysia will never be the same.

Then it was my turn. I opened, of course, with impromptu embarrassing anecdotes about Robin and Krysia, and then launched with alacrity into the planned recollections of the day before. It was fun, and everyone seemed to enjoy it. I was even able to finish with some stuff about what a wonderful bunch of people they all were without descent into control-threatening mawkishness.

And then it was done. I stayed until everyone else had gone before I followed suit - across

to the Tube and down to The London Clinic for the daily – and continuing - visit to the patients there. And then a welcome chance to debrief with Lindsay again, after the event: it would have been a sad end if I had not been able to share it that way.

I got home in the early evening. With a bracing glass of the expensive juice in my hand I ventured to open the white book, and it was then that it all finally got to me, and it became increasingly difficult to see the pages. There were at least a dozen long messages that read like fond obituaries, but with the unusual (for obituaries!) occasional use of the present tense in amongst the more conventional past, such as: "You were – and still are - the most . . ." as if hastily trying to reassure me that all was not lost. And then all the many other messages, shorter, that read like those on the funeral flowers, some with enough detail to be appropriate for an elaborate floral arrangement, and others, more dutiful, that would go nicely with a bunch of daffodils.

Those long anticipated two days had come and were almost gone. In idle moments over many years I had wondered how it would feel to leave St Mark's, and to see what my friends and colleagues – and I! - would make of it. Now I knew.

I have given myself the topic: "The day I arrived at St Mark's and the day I left" as my farewell lecture at the end of my Festschrift in November. What is there left to say?

Professor John MA Northover, London, 2012

Department Reports

Family Cancer Group

Director
Huw Thomas MA PhD FRCP

Physician
Andrew Latchford MD FRCP

Nurse Specialist
Carole Cummings RGN, SCM
To May 2014

Genetic Counsellor
Demetra Georgiou
From July 2014

Database Administrator
Maggie Stevens
Until March 2014

Referrals Administrator
Elizabeth Goodband

Secretary
Julie Jeffries

Introduction

The aim of our group is to define the inherited predispositions to colorectal cancer and to refine our management of familial risk in order to prevent familial colorectal cancer.

Maggie Stevens retired after eighteen years as database administrator and Carole Cummings after fourteen years as Clinical Nurse Specialist. Both provided fantastic service and are greatly missed.

Andrew Latchford, a former clinical research fellow in the Polyposis Registry, has been appointed as a Consultant Gastroenterologist at St Mark's and is taking an active role in the Family Cancer Clinic with a particular interest in Serrated Polyposis.

Demetra Georgiou has been appointed as a Genetic Counsellor by the Kennedy Galton Regional Genetic Service and is attached to the Family Cancer Clinic for half of her time.

Clinical Resource

We have the clinical details of over 3000 families at increased risk of familial colorectal cancer. Over 3000 at-risk family members have undergone a surveillance colonoscopy and are flagged by the NHS Information Centre. We have 150 new referrals each year.

Bobby Moore Database

The Bobby Moore Oracle Database is currently hosted by Imperial College London ICT at South Kensington. We successfully applied to Cancer Research UK for an infrastructure grant to create a new FileMaker Pro database that will be hosted by London North West Healthcare NHS Trust. The new database is being developed and will be more flexible, simpler to maintain and compliant with the new NHS Information Governance Framework. We are systematically reviewing and updating information on the current Bobby Moore database before the data is transferred to the new database. With the new database we will be able to undertake studies to look at the outcome of colonoscopic surveillance in different familial and genetic risk groups in collaboration with Professor Peter Sasieni.

Colonoscopic surveillance

Definition of the phenotype and management of Familial Colorectal Cancer

In collaboration with five other European centres (The Netherlands Foundation for Detection of Hereditary Tumours, The German Consortium for Hereditary Non Polyposis Colorectal Cancer, The Danish HNPCC-Register, Karolinska Institut Sweden, Manchester Regional Genetic Service) and Professor Peter Sasieni (Wolfson Institute for Preventative Medicine, Queen Mary College, University of London) we have published prospective data on the outcome of colonoscopic surveillance in families with at least three affected individuals with colorectal cancer consistent with dominant inheritance and in whom Lynch syndrome has been excluded.

We have shown that at-risk individuals do develop high-risk colonic adenomas but not until a later age and with no evidence of accelerated tumourigenesis. We have recommended that five-yearly colonoscopic surveillance be started from around the age of 40 (Mesher et al, 2014).

Colonoscopic surveillance

We have submitted a proposal to the NHS Bowel Screening Advisory Committee for the NHS Bowel Cancer Screening Programme to undertake

colonoscopic surveillance of Lynch syndrome gene carriers – a group who are at extremely high risk of developing colorectal cancer.

Molecular genetic studies

Hereditary Mixed Polyposis Syndrome

With Prof. Ian Tomlinson we have previously described the GREM1 gene alteration that causes HMPS. Dr Simon Needham and Prof. Tomlinson continue to investigate the role of GREM1 in the control of cell division in the colonic crypt (Davis et al 2015).

Next Generation Sequencing

Prof. Tomlinson continues to undertake whole genome sequencing in families with multiple cases of colorectal cancer in which known genetic predispositions to colorectal cancer have been excluded.

Genetics England 100k Genome Study

We will be recruiting patients to this study and Huw Thomas is a member of the rare diseases / inherited cancer Clinical Interpretation Panel.

Chemoprevention Studies

Colorectal Adenoma/carcinoma Prevention Programme 2 (CaPP2)

Further analysis has been undertaken on the outcome of the CAPP2. This study has already demonstrated a protective effect of 600mg of aspirin daily in preventing the development of colorectal cancer in Lynch syndrome and has now demonstrated that obesity is associated with an increased risk of colorectal cancer in Lynch syndrome (Moyahed et al 2015).

Colorectal Adenoma/carcinoma Prevention Programme 3 (CAPP3)

In 2015 – we started recruiting Lynch syndrome gene-carriers to CAPP3, a randomised dose-ranging study of aspirin chemoprevention (75mg, 300mg and 600mg).

Teaching and Patient Information

We continue to provide teaching and research projects to students undertaking a BSc in Gastroenterology at Imperial College School of Medicine.

With the Polyposis Registry we jointly organised a training day on the management of inherited colorectal cancer.

Dr Andrew Latchford, Consultant Gastroenterologist in the Wolfson Unit for Endoscopy, Assistant Director of the Polyposis Registry and physician for the Family Cancer Group, pictured here on the 9th May 2014

Polyposis Registry

Head of Department
Professor Sue Clark MD FRCS

Assistant Director
Andrew Latchford MD FRCP

Honorary Consultant Surgeon
Professor Robin Phillips

Honorary Consultant Paediatrician
Warren Hyer FRCP

Registry Manager
Kay F. Neale MSc

Nurse Practitioner
Vicky Cuthill BSc(Hons) RN

Nurse Practitioner
Ripple Man MSc, BSc RGN

Paediatric Nurse Practitioner,
Jackie Hawkins BSc(Hons) RN RSCN

Nurse Specialist
Patricia McGinty RGN

Assistant Administrator
Denise Coleman

Honorary Research Fellow
Allan D. Spigelman FRACS

Research Fellow
Sarah Jane Walton BSc MBBS MRCS

Research Fellow
Gui Han Lee MBBS MRCS

New members of staff 2014/2015

Nurse Practitioner
Jeshu Chauhan RGN

Administrator
Janet Paul

Research Fellow
Salman Rana MBBS MRCS BSc

Research Fellow
Chucks Anele MBBS BSc MRCS

Ninety Years Old

The Polyposis Registry was ninety years old in 2014. We celebrated in style with large birthday cakes at the annual Information Day for patients and their families which took place on 15th November and again on the 26th at the meeting for doctors, Frontiers in Colorectal Disease.

The Registry and the Trust

There were 247 new patient referrals, either with or at risk of a polyposis syndrome, to St Mark's in 2014 and 312 in 2015. Of these, 292 were referred directly to a consultant with the remaining 265 being referred as a result of Registry involvement with the family.

Registry Manager Kay Neale and Professor Sue Clark cut the cake to celebrate 90 years of the Polyposis Registry, 26th November 2014

New patient referrals	2014	2015
At risk of inheriting FAP or other polyposis syndrome	88	106
Other routine referrals	91	146
Peutz Jeghers syndrome	19	26
Juvenile Polyposis	12	17
MYH	37	17
Total	247	312

Education

In February 2014 the first of a series of six articles written by the nursing and administrative staff was published in *Gastrointestinal Nursing*. This overview was followed monthly by a more detailed article about each syndrome.

The International Society for Gastrointestinal Hereditary Tumours (InSiGHT)

The Registry continues to act as the Administrative Headquarters for InSiGHT. Professor Clark continues her role as Honorary Administrative Officer and Miss Neale continues her role as Honorary Administrative Secretary assisted by Mrs Hawkins. In June 2015 – the biennial meeting of InSiGHT was held in Sao Paulo. All members of the team had work accepted for presentation.

Oral presentations

Andy Latchford

- Long Term Data for Chemoprevention in Colorectal Disease in FAP

In addition, Dr Andy Latchford was invited to give the Eldon Gardner Lecture during which he spoke about the Management of the Upper GI Tract in FAP. Other members of staff presented their work in poster formation.

Sreelakshmi Mallappa

- Can Oral Rehydration Therapy Correct the Metabolic Disturbances and Improve Quality of Life After Colectomy?

Gui Han Lee

- Activated Systemic Dendritic Cell Phenotype in FAP – Does the APC Mutation Affect the Antigen Presenting Cells of the Innate Immune System?

Sarah Jane Walton

- Microrna Expression Associated with Desmoid Tumours in FAP
- The Forgotten Cancers in FAP
- Duodenal Disease in FAP
- Ureteric Complications of Intra-abdominal Desmoids

Donations

We should like to thank all those individuals who have donated funds to support our work.

Staff at the Polyposis Registry: Vicky Cuthill, Jackie Hawkins, Patricia McGinty, Denise Coleman, Rebecca Jones, 9th May, 2014

Sir Alan Parks Physiology Unit and National Neurostimulation Centre

Miss Carolynne Vaizey, the unit director, has worked in the department since 1995, firstly as a research fellow, then as an honorary senior research fellow and finally as the surgical consultant to the unit. She took over the directorship of the unit in 2007 when Professor Michael Kamm returned to Australia. Her specialist areas in addition to physiology and incontinence are anorectal surgical problems, intestinal failure surgery and Crohn's.

Ms Carolynne Vaizey, speaking at the Association Day, 26th October, 2010

She is the chair of the group working on commissioning Guidelines for Faecal Incontinence for NHS England, is the chairman of the Guidelines Committee at the ESCP (European Society of Coloproctology) and on the research committee at the ESCP.

Miss Vaizey now supervises all the work on neurostimulation with the help of Yasuko Maeda (senior surgical research fellow) and Greg Thomas (honorary research fellow). Follow-up of sacral nerve stimulation for incontinence now extends to more than 15 years and that of sacral nerve stimulation for constipation for up to 9 years. There are active ongoing research projects on other forms of neuromodulation along with exploration of new treatments for functional bowel disorders.

Dr Naila Arebi has been a consultant in the unit since December 2005. Her main interests in addition to oesophageal testing are in irritable bowel syndrome and inflammatory bowel disease.

The Biofeedback Service

The biofeedback service continues to see large numbers of patients with faecal incontinence and constipation from all over the UK (nearly 900 new patients were seen each year). At the end of 2013 Sister Brigitte Collins took over from Christine Norton as the head of biofeedback. Since then the unit has expanded to 8 therapists, all with their own sub-specialist interests. Brigitte is not only the Head of the unit she is also a qualified hypnotherapist.

Sister Ellie Bradshaw is the neurostimulation specialist nurse and also has an interest in the treatment of bowel problems after pelvic cancer – her MSc thesis was also on this topic. There is a new collaboration between the unit and Dr Ana Wilson and Dr Siwan Thomas-Gibson, gastroenterologists with a specialist interest in endoscopy providing world class treatment for patients after cancer treatments.

Sister Anna Swatton has an interest in body image and sexual problems secondary to the bowel, a common problem with incontinence, constipation, anal diseases and after cancer treatments. Sister Rebecca Knox treats bowel problems in adolescents as well as in adults; she works with Warren Hyer, St Mark's paediatric gastroenterologist, looking after the teenage patients.

There are two physiotherapists on the biofeedback team – Trish Evans who has an interest in anal pain and Rhian Sunderland who treats patients with both urinary and bowel problems. Diane Brundrett is a dietician who has joined the unit to run a Bloating Clinic. Avril Burns is a psychotherapist who has joined the unit providing support for the functional bowel patients. Fareed Iqbal was appointed in October 2013 as SNS fellow and medical officer following the departure of Greg Thomas. Greg completed his MD thesis on neuromodulation for functional bowel disorders and is now enrolled into a surgical training programme at the London Deanery. Alex Dennis has been appointed as a new clinical physiologist. Clinical physiologists are continuously refining measurement techniques and the Unit also provides Bravo™ oesophageal pH testing to compliment the traditional 24 hour catheter-based system. This represents a less invasive method of performing oesophageal pH studies with no limitation on patients' activities caused by a naso-oesophageal catheter.

Diagnostic studies

The Physiology Unit offers a range of diagnostic studies including stationary oesophageal manometry, ambulatory oesophageal pH and manometry studies, breath hydrogen studies and studies of pelvic floor function. During 2014 and 2015 – more than a thousand of these procedures were performed.




Top: Brigitte Collins (head of biofeedback), Alex Dennis (clinical physiologist)
Bottom: Ellie Bradshaw (neurostimulation specialist), Yasuko Maeda (senior surgical research fellow)

Top: Dr Michele Marshall examines a patient's MRI record.
Below: Consultant Radiologists Dr David Burling and Dr Arun Gupta.

Intestinal Imaging Centre

Head of Department
Dr Michele Marshall

Consultant Staff
Dr David Burling
Dr Arun Gupta
Dr Rajapandian Ilangovan
Dr Uday Patel

Research Fellows
Dr Antoni Sergot
Dr Francois Porte
Dr James Burn
Dr Alison Corr
Dr Anu Obaro

Radiographers

St Mark's Gastrointestinal Superintendent and Research Radiographer
Rachel Baldwin

CTC Service Manager
Janice Muckian

New Members of Staff 2014 and 2015

CTC Radiographer
Michael North

Consultant Radiologist
Dr Phillip Lung

Consultant Radiologist
Dr Evgenia Mainta

2014 and 2015 were great years for the Intestinal Imaging Centre. Our CT Colonography service continued to expand with published data highlighting our experience of CTC service implementation. Since then, we have had an increase in demand rising from 2098 in 2014 to 2511 in 2015.

Our unit works closely with surgical and nursing colleagues to deliver exceptional quality for our complex cancer patients with in depth discussions prior to joint clinicoradiology clinics where all of the team see the patient.

Research remains an important focus for intestinal imaging with our department involved in multicentre trials, such as METRIC, comparing MR enterography against small bowel US and STREAMLINE, investigating the utility of full body diffusion MRI in colorectal cancer.

The St Mark's Intestinal Imaging Centre was also the largest contributor to the SIGGAR study, which was a multicentre randomised trial to evaluate CT colonography versus colonoscopy or barium enema for the diagnosis of colonic cancer or large polyps in symptomatic patients.

Professor Brian Saunders in the endoscopy procedure room, 30th January 2014.

Wolfson Unit for Endoscopy

Head of Department
Professor Sue Clark

Director of Endoscopy and Bowel Cancer Screening
Prof Brian Saunders

Clinical Lead
Dr Adam Humphries

Training Lead
Dr Adam Haycock

Clinical Manager
Sarah Marshall

Service Manager
Aneta Cwick

Administrative Manager
Jean Mannings

Consultant Staff

Deputy Director for Bowel Cancer Screening
Dr Siwan Thomas-Gibson

Lead for GI Consequences of Cancer Treatment
Dr Ana Wilson

Endoscopy Training Lead
Dr Adam Haycock

Consultant Endoscopist
Dr Noriko Suzuki

Deputy Director for Polyposis
Dr Andrew Latchford

Nurse Consultant and Deputy Director, Bowel Cancer Screening London Hub
Margaret Vance

Nurse Endoscopists

Jayne Butcher
Belma Motes
Mary Rendle
Ana Buenaventura
Ripple Man
Angeline Chai

Capsule Endoscopy Nurse Specialists
Aine O'Rourke
Monika Rzeznikiewicz

Medical Secretaries
Bharti Jhuti
Smita Patel

PA for Bowel Cancer Screening
Alice Merrigan

Audit and Training
Jon Walton

Lead Specialist Endoscopy Nurse
Trushma Patel

New Members Of Staff 2014 and 2015

Consultant Gastroenterologist
Dr Adam Humphries

Endoscopy Service Manager
Ms Aneta Cwik

Nurse Endoscopist
Belma Motes

Nurse Endoscopist
Angeline Chai

Capsule Endoscopy Nurse Specialist
Monika Rzeznikiewicz

I was delighted to be appointed to the Consultant staff in Endoscopy in 2014 and have since taken over as Clinical Lead for endoscopy from Dr Siwan Thomas-Gibson in 2016 – an unenviable task! The endoscopy unit continued to expand in 2014 and 2015 – with both my appointment and several additions to the pre-assessment, nursing, administrative and management team. Sarah Marshall and Aneta Cwick were appointed as Clinical and Service Manager respectively, and have been outstanding in maintaining the service and pushing the unit forward.

We were proud to have our status as the only designated centre of excellence for endoscopy in the UK, awarded by the World Endoscopy Organisation (WEO), renewed in 2015. The Wolfson Unit also successfully had its JAG accreditation, a mark of quality awarded to endoscopy units in the UK, renewed in November 2015 after a rigorous inspection and audit of the unit.

The unit continues to perform tertiary and specialist endoscopy and also deliver a high quality service to the local population of Harrow and Brent. A 'direct to test' pathway for patients referred with suspected lower GI cancers has been instituted, with the development and appointment of specialist nurses to run the Endoscopy Radiology and Outpatient Service (EROS), led by Dr Siwan Thomas-Gibson in endoscopy. Dr Ana Wilson has set up a specialist tertiary service to treat patients who have GI consequences of cancer treatment and Professor Brian Saunders has instituted a bimonthly polyp meeting to discuss complex cases. The ongoing roll out of Bowel Scope Screening has resulted in a significant expansion of the bowel cancer screening service that we deliver to the population of North West London.

As a national training centre, Dr Adam Haycock has continued to deliver a number of national training courses in endoscopy, supported by the consultant staff as faculty. We also continue to demonstrated 'live' endoscopy at the Annual International Frontiers Congress at St Mark's and both Prof. Saunders and Dr Thomas-Gibson have been invited to demonstrate live endoscopy at several international meetings. We have also run a number of postgraduate courses and regional training days for specialist registrars.

The consultant staff within the unit continue to deliver an impressive academic output, supervising a number of research fellows, including

publications in international peer-reviewed journals, oral presentations and abstracts at national and international meetings. In addition, many of the consultants sit on a number of national committees relating to endoscopy and training and are involved with the development of national guidelines and national standards of clinical practice.

There continue to be many challenges to the service, with ever increasing demand and limited financial resources, however the outstanding nursing, medical, administrative and management teams have been able to meet these and I have every confidence we can continue to do so.

Dr Adam Humphries MBBS BSc PhD MRCP
Consultant Gastroenterologist & Endoscopist

Dr Adam Haycock illustrates snare technique to Tim Elliott during an Endoscopy Train the Trainers meeting, 2nd May, 2013

Top: Dr Ailsa Hart outside the St Mark's Hospital entrance
Below: Dr Ailsa Hart during a training session with St Mark's clinical research fellows.

Inflammatory Bowel Disease Unit

Director
Dr Ailsa Hart

Lead IBD Surgeon
Mr Janindra Warusavitarne

Lead IBD Specialist
Nurse Miss Marian O'Connor

Gastroenterologists
Dr Ayesha Akbar
Dr Naila Arebi
Dr Simon Gabe
Dr Adam Haycock
Dr Meron Jacyna
Dr Andrew Latchford
Dr Jeremy Nightingale
Dr S O'Brien
Dr Maxton Pitcher
Prof Brian Saunders
Dr A Sharif
Dr D Sherman
Dr Siwan Thomas Gibson
Dr Ana Wilson

Paediatric Gastroenterologist
Dr Warren Hyer

Colorectal Surgeons
Mr Janindra Warusavitarne
Mr Omar Faiz
Professor R Phillips
Miss Carolynne Vaizey
Mr Ian Jenkins
Prof. Robin Kennedy
Prof. Sue Clark

IBD Clinical Nurse Specialists (CNS)
Marian O'Connor (Consultant Nurse)
Tracey Tyrrell
Hannah Middleton
Kay Crook (Paediatric CNS)

IBD Day Care Unit Staff Nurse
Monica Waga
Guia Penonia

Secretarial and administrative support
Anne Wheelhouse *from 2015 onwards*
Susan Osborne *18 hours per week*
Felicity Taylor *left in 2015*

Research Coordinator / Nurses
Lawrence Penez
Ed Carbonell *from 2015 onwards*
Reggie Encarnado *left in 2015*

The IBD Service

Dr Ailsa Hart is director of the Inflammatory Bowel Disease (IBD) Unit at St Mark's Hospital. Mr Janindra Warusavitarne is the lead colorectal surgeon for the IBD service. Marian O'Connor, nurse consultant, leads the IBD specialist nursing team. The IBD Unit has gone from strength to strength, by building up the staff (specialist nurses, dieticians, research fellows and research nurses) and driving forward the IBD research agenda. The team are recognised nationally and internationally for their contribution to clinical service development, delivery, research, teaching and education.

The IBD team look after approximately 5,000 patients with inflammatory bowel disease from both local populations and nationally. The service has a multidisciplinary team approach to patient care which includes gastroenterologists, colorectal surgeons, IBD specialist nurses, psychologists/psychiatrists, pharmacists and dieticians. There are daily IBD clinics. The multidisciplinary team meet weekly to discuss complex cases on a Wednesday morning and hold a virtual biologics meeting (VBM) on a Friday lunch time to discuss the patients on biological treatments. There is also a monthly joint transition clinic for adolescents with IBD with Dr Warren Hyer, paediatric gastroenterologist.

The IBD specialist nursing team led by Marian O'Connor provide a first class service for patients with IBD. Marian was promoted to consultant nurse for IBD in 2014, making her the first IBD nurse consultant in the UK. Tracey Tyrrell has taken on the position of lead IBD nurse (January 2015). The service offers support, education and a point of access to advice and treatment delivered through nurse-led clinics, advice line (telephone and e-mail) and a dedicated day unit.

The IBD nursing service has now been running for 13 years during which time the service activity has greatly increased. The advice line activity has grown from 400 calls in 2003 to 3200 calls in 2014 and 2015. The dedicated nurse-led IBD day care unit is now open 5 days per week. Nurse led follow-up clinics and telephone review clinics are also offered.

Along with the above detailed services, the nursing team coordinates the weekly IBD multi-disciplinary team meeting, the VBM and monitors blood test results for patients taking immunosuppressant medications. The IBD team support the patient panel which meets every 2 months and the IBD open day took place in November 2015. The team continue to have a high profile nationally and internally lecturing and publishing their work. Marian O'Connor and Kay Crook completed their MSc in 2014.

Clinical Research

The clinical research within the IBD Unit is expanding, with more commercial, investigator initiated and translation research trials being conducted. Over 10 commercial and academic studies were being conducted in 2014 to 2015. We recruited Mr Ed Carbonell in 2015 as an IBD research nurse to assist Lawrence Penez in trial delivery.

Laboratory / Translational Research

Research from the IBD Unit has led to publishing in high impact journals and members of the team are invited to lecture globally. Over 40 papers were published in peer reviewed journals in 2014 and 2015 and over 60 abstracts/posters. Nuha Yassin and Jonathan Landy completed their PhDs in 2015. Simon Peake, completed his MD, Pritesh Morar, YihHarn Siaw, Ryan Choi, Rakesh Vora, Phil Hendy, John Nik Ding, Kapil Sahnan, Sam Adegbola, Jonathan Segal, Ravi Misra and Ibrahim Al Bakir are all currently undertaking higher degrees in IBD.

Research projects include assessment of causes and novel treatment of perianal fistulating disease, causes and novel treatments for wounds in Crohn's disease, causes and novel treatments for pouchitis including faecal transplantation, IBD surveillance and assessment of the inflammation to cancer pathway, role of vitamin D in IBD and its potential as an adjunctive therapy, assessing and optimising response to biologic drugs, role of gut microbiota in pathogenesis of IBD. Many research fellows have achieved commendations for their excellent contribution to research in the form of a post of distinction at national and international meetings.

Teaching / Education / External Visibility

The IBD team has achieved excellent external visibility. Prof. Hart was elected as a member of the International Organisation of IBD (IOIBD), which recognises her contribution to research and education at the national and international level. She is one of only 50 top IBD clinicians globally elected to the organisation.

Prof. Hart is Chair of the British Society of Gastroenterology (BSG) Gut Microbiota for Health Group, is a panel member of the BSG Clinical Research Group for IBD and one of 5 elected members to the clinical committee of ECCO (2013–2015). She is editor of the journal Alimentary Pharmacology and Therapeutics and is the UK lead for Patient and Public Involvement. Marian O'Connor expertly led and chaired the Nursing Committee of ECCO for 3 years. Mr Warusavitarne is an elected member of the Surgical Committee at ECCO (S-ECCO). Mr Omar Faiz is chair of ACPGBI IBD committee, chair of the UK Ileal Pouch Registry and surgical representative to the UK IBD Audit and IBD Standards.

Dr Jeremy Nightingale was medical representative on NICE (clinical guideline 166), ulcerative colitis – management in adults, children and young people. Dr Naila Arebi has efficiently led St Mark's contribution to the National UK IBD audit.

It is with thanks to the enthusiasm, dedication and hard work of the whole IBD team that the IBD Unit is prospering as the leading IBD Unit nationally.

Mr Janindra Warusavitarne, Consultant Colorectal Surgeon, Lead IBD Surgeon

Biofeedback Team

Head of Department
Brigitte Collins, Lead Nurse
Specialist interest in Hypnotherapy

Clinical Nurse Specialists

CNS Elissa Bradshaw
Specialist interest in Neuromodulation

CNS Anna Swatton
Specialist interest in Psychosexual

Clinical Biofeedback/ Physiotherapy Specialist
Patricia Evans
Specialist interest in anal pain/pelvic floor dysfunction

Training post for biofeedback therapy
Rebecca Arnold
Specialist interest in Adolescents

Clinical Biofeedback/ Physiotherapy Specialist
Rhian Sunderland from July 2015
Specialist interest in Urology

Counsellor Specialist in Biofeedback Therapy
Avril Burns

Advanced FODMAP dietician in Biofeedback Therapy
Diane Brundrett

New members of staff (2014/2015)

Rebecca Knox has taken on the post in biofeedback training and is currently working her way towards achieving Clinical Nurse Specialist status.

Lorraine O'Brien who worked for biofeedback therapy for 10 years retired in April 2015. She has been replaced with Rhian Sunderland, Physiotherapist who has re-located from Liverpool and commenced her post in July 2015.

Diane Brundrett commenced a specialist dietician clinic.

Biofeedback is a nurse-led service headed by Lead Nurse Brigitte Collins, MSc, BSc (Hons) RGN – Diploma in Hypnotherapy. It is the largest nurse-led biofeedback unit and is widely recognised as a world leading centre of excellence. The biofeedback team consists of specialist nurses and physiotherapist specialists who manage patients who present with a range of functional gastrointestinal disorders including constipation and faecal incontinence as the two largest groups.

The biofeedback team are celebrating 30 years of service this year. The service originally commenced and was delivered in 1986 by Professor Michael Kamm who at the time was a registrar. The treatment results initially were not effective; Professor Kamm therefore enlisted the help of a Greek consultant already practicing biofeedback therapy. With this input, delivery of the treatment improved patient outcomes, and has

Staff from the Biofeedback team: (top) Rhian Sunderland, Elissa Bradshaw, Avril Burns, Anna Swatton, Brigitte Collins, Rebecca Knox, (below) Rhian, Brigitte and Elissa at a Biofeedback meeting

become and continued to be a great success.

The service since then has developed and evolved to a team of eight with each therapist practising their own sub-speciality. This in turn increases the range of therapeutic options as an individualised package of care, thus expanding and adding treatments to the pathways.

New treatments include the use of Linaclotide, new irrigation equipment and inserts plus there is now a service for Percutaneous Tibial Nerve Stimulation and Transcutaneous Tibial Nerve Stimulation, Hypnotherapy, Adolescent Service, Counselling Service and FODMAP dietician service. As a result this increases the prospects of enhancing patient outcomes, which already stands at an overall 84% improvement.

The lead nurse has been responsible for organising 2 master classes with members of the team teaching principles applicable to the required knowledge:

- One for colorectal nurse specialists/therapist/physiotherapists for biofeedback therapy, in particular elements that may help the healthcare professional within their practice.
- The second master class was set up for continence advisors to cover the components that are expected at Level 1 in the RCS Commissioning FI Guidance.

To raise the profile of the biofeedback service and its developing team Brigitte Collins has been invited and joined the following boards:

- Coloplast Continence Advisory Board
- RCN Steering Committee for GI Nursing Forum
- Bowel Interest Group for Constipation Pathways
- Coloplast Web Editorial Board
- A new and ongoing development is the pathways for constipation on the back of current published data, which shows a significant cost to the NHS via A&E admissions, hospital stay and prescribed laxatives for constipation.

To raise the profile of SNS Ellie Bradshaw currently attends the experts SNS Advisory Board.

Teaching includes the following:

- Preceptorship nurse training for constipation and faecal incontinence. (Anna Swatton)
- Anterior resection study day. (Brigitte Collins with Claire Taylor)
- Coloplast Symposiums (Brigitte Collins)
- Biofeedback Therapy Masterclass (Brigitte Collins and Anna Swatton)
- Post Graduate, St Marks. (Biofeedback team)
- Ward specialist teaching (Rhian Sunderland)
- Continence Advisors Masterclass (Brigitte Collins and Anna Swatton)

The All Party Parliamentary Group for Continence Care has recommended defined care pathways for people with bladder and bowel symptoms. Our service provides a national resource for referral for patients who do not respond to primary and secondary care interventions, thus meeting the requirements for RCS FI Guidance and the APPGCC.

Research Activities

Brigitte Collins and Lorraine O'Brien completed a small pilot study for Percutaneous Tibial Nerve stimulation (PTNS) for chronic anal fissure.

Psychological Medicine Unit

Head of Department
Dr Yoram Inspector
MD, Consultant Psychiatrist, Psychotherapist

Consultant Psychologist
Dr Esther Serrano-Ikkos

Consultant Psychologist in Psychotherapy
Ms Megan Virtue

New members of staff (2014/2015)

Honorary Clinical Hypnotherapist
Mr Bansi Saha

Locum Consultant Psychiatrist in Psychotherapy
Dr Helen Johnston *to August 2015*

The Psychological Medicine Unit of St Mark's Hospital (PMU) continues to provide psychiatric and psychological treatment and support to patients who suffer from various gastrointestinal diseases and disorders.

Our clinical activity included:

- Psychiatric and psychological assessment and ongoing short and long term psychotherapy to outpatients (Dr Esther Serrano-Ikkos specialises in Eye Movement, Desensitisation and Reprocessing Therapy (EMDR) which facilitates recovery from psychological trauma; Ms Megan Virtue focuses on Psychoanalytic Oriented Psychotherapy and Dr Yoram Inspector provides psychiatric assessments, psycho-pharmacology and integrative psychotherapy which integrates supportive , cognitive-behavioural and psychodynamic (mainly in a Jungian and self psychology orientation) elements. We try to individually tailor the suitable approach to each unique person and problem.
- Psychological support to the inpatients of the Intestinal Failure Unit most of which are in an acute adjustment crisis to their gastrointestinal illness (for example depression, suicidal ideation, difficulties in coming to terms with living with a stoma bag or Parenteral Nutrition).

The PMU also continued to provide supervision to St Mark's Clinicians on working with patients who present with difficult psychological issues: every Monday between 13.00–14.00 the Psycho-Social Meeting takes place (at the seminar room near the IF Unit) during which the PMU

Dr Yoram Inspector MD, Consultant Psychiatrist, Psychotherapist

team members meet with St Mark's clinicians (everyone is welcome) to discuss these complex patients, who then commonly are continued to be supported by the PMU.

Dr Yoram Inspector continued to provide regular group supervision to the biofeedback nurses, the IBD nurses and the clinical dietitians.

As regards to the academic and the psycho-education aspects, Dr Yoram Inspector continued to lecture on various aspects of psycho-gastroenterology. These were some of the topics: 'Stress and IBD – Chicken or Egg?' presented jointly with Dr Naila Arebi at the 2014 Frontiers; 'Psychological Aspects of Abdominal Pain' given at the Royal Society of Medicine; 'Disordered Eating and Eating Disorders in Patients who suffer from Functional Gut Disorders' given at the UCL annual Nutrition course jointly with Dr Paul Robinson; 'The Psychological impact of Home Parenteral Nutrition' given at the annual Leeds Nutrition Course.

'The Psychological Aspects of Inflammatory Disease' given in different conferences dedicated to IBD in Leeds Manchester, Birmingham and St Mark's.

'Psychological Aspects of Abdominal Pain' given at the Royal Society of Medicine; 'Disordered Eating and Eating Disorders in Patients who suffer from Functional Gut Disorders' given at the UCL annual Nutrition course jointly with Dr Paul Robinson; 'The Psychological Impact of Home Parenteral Nutrition' given at the annual Leeds Nutrition Course.

'The Psychological Aspects of Inflammatory Bowel Disease' given in different conferences dedicated to IBD in Leeds Manchester, Birmingham and St Mark's. Dr Inspector also wrote jointly with Dr Philip Hendy and Dr Ailsa Hart a chapter in the pioneering book 'Psychological Aspects of Inflammatory Bowel Diseases – Bio-Psycho-Social Approach'. The chapter is entitled 'Standard Medical Care, Side Effects and Compliance'.

Dr Inspector also lectured on the annual open days for patients who suffer from IBD and on the open days for patients who suffer from familial polyposis.

Developments and plans for the near future:

- To develop further and consolidate the field of gut-oriented hypnotherapy which is an evidence-based, cost effective and NICE recommended therapy for functional gut disorders. Mr Bansi Saha our honorary clinical hypnotherapist has done a lot of successful work in this domain with outpatients and inpatients on the wards.
- To address the acute need to have a service for the psychological management of abdominal pain which potentially will reduce opiate abuse. A research project to explore the efficacy of cognitive behavioural therapy, mindfulness stress reduction, acceptance and commitment therapy and hypnotherapy in improving coping with chronic abdominal pain has been proposed.

The main problem of the PMU remains the limited professional resources. We hope to expand and add more people who could work full or maximum part-time as the demand for psychological support exceeds unfortunately the capacity to provide it promptly and consistently.

Department of Paediatrics

Department Lead
Consultant Paediatric Gastroenterologist
Dr Warren Hyer

IBD nurse practitioner, IBD unit
St Mark's Hospital
Ms Kay Crook

Polyposis nurse practitioner
St Mark's polyposis registry
Ms Jacky Hawkins

Lead for IBD transition care
Professor Ailsa Hart

Lead for St Marks Polyposis Registry
Professor Sue Clark

Consultant Gastroenterologist, St Mark's Polyposis Registry
Dr Andrew Latchford

Polyposis Registry St Mark's Hospital
Ms Kay Neale

Consultant paediatric gastroenterologist (Chelsea and Westminster Hospital)
Dr J Fell FRCP FRCPCH

Consultant Endoscopist, Wolfson Unit
Dr Adam Humphries MRCP

Consultant Endoscopist, Wolfson Unit
Professor Brian Saunders FRCP

Consultant paediatric endocrinologist
Dr A Massoud MRCP MRCPCH MD

Paediatric secretary and clerical support for paediatric endoscopy
Mr Jamie Reeves

Paediatric dietician
Miss Jo Feneck and Justine Dempsey

Lead dietician for enteral nutrition
Mrs Nicole Rothband

Sister, Jacks Place inpatient unit
Jackie Waldron

New members of staff (2014/2015)

Paediatric Dietician
Alexa Evans
HCA
Ebony Glanville

The 2 years of 2014 and 2015 has seen the division of paediatric gastroenterology become recognised as a centre for excellence both for paediatric polyposis, and paediatric inflammatory bowel disease.

The British Society of Paediatric Gastroenterology has consistently recognised the polyposis service as a national resource, with referrals from across the UK, patients at risk of, or confirmed to be affected by a polyposis syndrome. As the complexity of some of these cases has increased, so the multi-disciplinary team has developed plans for clinical care, offering complex endoscopic and surgical expertise to children as young as 4 years old. Professor Clark and the polyposis registry have met with the paediatric gastroenterology team twice a month

advising on aspects of care previously not available to children. Jackie Hawkins, at St Mark's Hospital is probably the only paediatric polyposis nurse practitioner in the world, ensuring children and adolescents are offered the highest standard of care at screening and therapy, and creating transition adolescent service. With this expertise, St Mark's is now leading an international consortium of experts writing and publishing guidelines to manage children and adolescents with polyposis syndromes on behalf of the European and North American Paediatric Gastroenterology Societies.

In 2015 – our IBD service was one of a handful visited and highly commended by the Royal College of Physicians, lead reviewer Dr Russell. In all areas of care we were complimented, especially with our joint care with surgeons, endocrinologist and world class leaders in endoscopy.

Novel and new interventions made available by the department include sedation endoscopy lists for adolescents, single day service for polyposis patients (endoscopy and clinic appointments same day), a burgeoning one stop clinic for food allergy clinic, patient open days for children and adolescents for IBD and polyposis.

Academic achievements this year include:

- Authored chapters on paediatric Polyposis in two textbooks of paediatric gastroenterology
- Abstracts accepted to ESPGHAN and InSight meetings
- Lead for working group in Paediatric Polyposis for ESPGHAN
- Hosting the national trainees meeting for BSPGHAN 2015
- Lecturing at RSM, national allergy days.
- Presentations at BSPGHAN and ESPGHAN
- Lecturing on international paediatric conferences in paediatric gastroenterology

Our department is indebted to its two full time allocated paediatric nurses, Ms Kay Crook and Jacky Hawkins who deliver specialist care to our local and national referrals to the highest standards, ensuring we are recognised as a international centre of excellence for our paediatric gastroenterology services.

Dr Warren Hyer (Paediatrics Department Lead), 2nd May 2014

Nurse Education

Senior Lecturer
Pat Black

Clinical Nurse Specialist
Jennie Burch

Having moved from Hillingdon hospital in 2013 to St Marks Hospital, Pat brought several established colorectal nursing courses to the Trust.

These six day residential courses are funded by Dansac, an ostomy company who have been affiliated with St Marks for many years. The university which the courses are linked with is Birmingham City University who have a good academic history within the UK. The delegates on these courses are nurses from the ward, stoma care specialist nurses and colorectal nurse specialists.

During this period Pat was the module lead on two Masters level courses 'Colorectal cancer care for advanced practice'. Each of these specialist courses attracted eight delegates; one from St Marks Hospital.

Pat also was the module lead for four degree level courses entitled 'An advanced approach to stoma management'. These courses attracted 11–17 delegates with a total of 51 delegates attending. There were four nurses from St Marks Hospital including two St Marks Burdett Scholars.

Finally Pat was the module lead on three diploma level courses 'Foundations for practice in stoma care'. These courses attracted 10–12 delegates; with one nurse from St Marks. There were a total of 33 delegates, including 11 from Scotland.

Pat also coordinated or assisted during this time frame with several one day masterclasses that were funded by Dansac:

- The knowledge, skills and practicalities master class ran in March 2014. There were 28 delegates; with three nurses attending from St Marks Hospital.
- The fistula master class ran in June 2014. There were 40 attendees of whom eight were nurses from St Marks Hospital.

- The siting master class ran in November 2015. This masterclass attracted 18 delegates; with three nurses from St Marks Hospital.

Claire Taylor led on the gastrointestinal nursing one day conference that was held in November 2014 with assistance from Pat. A charge of £50 was made to external delegates. There were 81 delegates attending with five nurses attending from St Marks.

Pat organised several nurse observerships. There were three nurses attending for one day, one nurse attended for two days and one nurse spent two weeks at St Marks.

Having successfully gaining funding from the Burdett Institute Trust for Nursing to train two nurses each year for three years with Claire Taylor, the scholarship commenced in August 2015. During this time period the scholars attended the degree module and began their rotation around the nursing departments of St Marks Hospital.

During this two year period, 272 nurses have undergone 72 days of training. This figure includes 25 nurses from St Marks Hospital.

This does not include all the education undertaken by each specific nursing department who have been involved in one day courses and observerships.

Written by Jennie Burch on behalf of Pat Black

Pathology

Consultant Histopathologists
Morgan Moorghen
Alan Baird
Lajja Panchal

Consultant Histopathologists
Adriana Martinez
Ezra Nigar

In the past year the service has seen a significant increase in activity mainly due to the expansion of endoscopy work and in particular bowel cancer screening endoscopy. There has also been a big change in management as the laboratory is now run by a private company TDL Ltd in line with the recommendations of the Carter report on the provision of pathology services in the NHS. The department continues to make improvements in quality and exceeds the national standards set by the bowel cancer screening programme for example. All our histopathology reports conform fully with the requirements set out by the Royal College of Pathologists and the department runs a tight audit programme which helps to monitor and maintain high standards. This year has also seen a small increase in the number of external referrals for second opinions.

In terms of training SpRs in histopathology, this department is part of the north west London rotation and we are currently at maximum capacity, housing four trainees in histopathology all of whom have to spend a few months in GI pathology. This year has once again seen an excellent pass rate at the final FRCPath examinations and as result we are seeing an increasing number of requests for short-term attachments both locally and from abroad. In February of this year we ran our third successful annual GI histopathology workshop which received excellent feedback.

The department continues to make significant contributions to the research activities of St Mark's hospital. In this regard the archives of tissue blocks which go back more than 40 years have proved to be an invaluable resource to our clinical fellows engaged in PhD and MD projects. There is also external collaboration with research groups at Bart's and Royal London and University of Bristol. The department also contributes material to an increasing number of national trials in colorectal cancer and inflammatory bowel disease.

Consultant Histopathologist and training programme director in histopathology for North West London, Dr Morgan Moorghen, 9th May 2014

Department of Surgery

Director & Consultant Surgeon
Professor Robin Phillips MB BS MS FRCS

Consultant Surgeon & Dean
Professor Sue Clark MB BCHir MD FRCS (Gen Surg) EBSQ (Coloproctology)

Consultant Surgeon
Ms Carolynne Vaizey

Consultant Surgeon
Mr Janindra Warusavitarne

Consultant Surgeon
Mr Omar Faiz

Consultant Surgeon
Mr Anthony Antoniou
BSc MB BChir MS FRCS (Gen Surg)

Consultant Surgeon
Mr Peter McDonald

Consultant Surgeon
Professor Robin Kennedy MS MBBS FRCS

Consultant Surgeon
Mr Ian Jenkins

The Surgeons have been delighted to have the new theatre 11 for St Mark's – it has brought daylight and space and the upgraded AV allows high definition images in The Clore Lecture Theatre and Postgraduate Room. There has been an increase in the number of RSOs who now total eight – two from NW London, two from the other Thames rotations and four others.

PROF. ROBIN PHILLIPS

Robin Phillips continued as Clinical Director with responsibilities for St Mark's, Gastroenterology, Upper GI Surgery and Emergency Surgery as well as incorporating Ealing. He continued to run an annual Fistula Study Day with Dr Ailsa Hart. Mr Phil Tozer was awarded MD and Miss Nuha Yassin PhD for their work on anal fistula. Sam Adegbola and Kapil Sahnan continue the fistula research. He lectured in the Wirral and at the Excel Centre in London, as well as overseas in Fort Lauderdale, Riyadh, Turin, Madeira, Belgrade, Czech Republic, Santander and Athens.

PROF. SUE CLARK

Professor Sue Clark continued as the Educational Supervisor for RSOs. She continued to do large volumes of surgery for FAP and ileo-anal pouch work, including revision, and are the highest volume pouch service in the UK.

She became Dean of St Mark's Hospital, taking over from Professor Robin Kennedy after five years in the role.

MS CAROLYNNE VAIZEY

Miss Carolynne Vaizey continued as the Chair of Surgery for St Mark's. She is also the Director of the Physiology Unit and Lead Surgeon for Intestinal Failure. Miss Vaizey represents St Mark's at the Federation of Specialist Hospitals.

She has also continued her responsibilities with the European Society of Coloproctology as a Member of the Executive Committee, Chairman of their Guidelines and Standardisation Committee and a Member of the Research Committee.

She has also been a Member of the Advisory Committee for National Service Redesign for Intestinal Failure for NHS England and Chairman of the European Consensus Group on Surgical Management of Intestinal Failure.

Miss Vaizey has research fellows in neurostimulation and intestinal failure. She has lectured at the Royal College of Surgeons, the Royal Society of Medicine, the Pelican Centre in Basingstoke and overseas in Switzerland, Mauritius, Riyadh, Lisbon, Amsterdam, Dublin and Sri Lanka.

Top: Prof. Robin Kennedy and Susana Ouro in Theatre 6 before refurbishment, 10/09/2013.
Below: Prof. Robin Phillips and Dimitrios Patsouras – Soave's operation, 25/10/2012.

MR JANINDRA WARUSAVITARNE

Janindra Warusavitarne continued as consultant colorectal surgeon and developed his interests in surgery for IBD. He is a committee member of the s-ECCO and ACP chapter representative for North West Thames.

He has been involved in writing guidelines for surgery for Crohn's disease and has been an active member of the executive team of the European board surgical qualification. He has published papers and written book chapters and delivered many national and international lectures.

MR OMAR FAIZ

Omar Faiz continued his surgical and academic work for St Mark's throughout the last year. His principal clinical responsibilities are to the patients suffering from Inflammatory Bowel Disease, Polyposis and Colorectal Cancer. He continued his work throughout this time as the Director of Research and Director of the Surgical Epidemiology, Trials and Outcome Centre (SETOC). Over the course of the year Mr Faiz and his research team published twenty-five papers in peer-reviewed scientific journals. Mr Faiz's current PhD fellows; Guy Worley, Henna Rafique and Chuks Anele are undertaking exciting projects on Ulcerative Colitis, colorectal cancer in the elderly and hereditary bowel cancer respectively. In the last year he gave seventeen lectures at meetings in ten different countries. In addition to the above Omar Faiz continues his responsibilities as the Association of Coloproctology of Great Britain & Ireland (ACPGBI), Chairman of the IBD Subcommittee and the Chair of

Janindra Warusavitarne with the laparoscopic single port accessory, 2015

the Ileal Pouch Registry. He continues in his role also as Chairman of an international benchmarking group in gastrointestinal surgery (Global Comparators group). In 2015 he also commenced work as an Associate Editor for the journal Colorectal Disease.

MR ANTHONY ANTONIOU

Anthony Antoniou continued in his role as Joint Cancer Lead for colorectal and anal cancers at St Mark's. He also continued in his role as one of two surgeons providing a complex cancer/recurrent cancer service. Patients with advanced disease continued to benefit from the multidisciplinary approach in the treatment of their disease. He had a research fellow studying the outcomes of complex cancer surgeries at St Mark's Hospital and also collaborated with leading researchers at Bart's Hospital in to the understanding of the development of recurrent colorectal cancer. He continued to be active in clinical teaching Imperial College medical students. He is contributing to the advancement in innovation at St Mark's Hospital by being involved in the introduction of robotic colorectal surgery.

MR PETER McDONALD

Peter McDonald continued to work as both a general surgeon at Northwick Park Hospital as well as performing coloproctological procedures at St Mark's Hospital. He is Chairman of Northwest Thames Paediatric Surgical Network, a Non-Executive Director of the MDDUS and a Medical Adviser to CS Healthcare. He gave an Oration at Christchurch College Oxford – Festschrift for Professor Mortensen on the 3rd October 2015 – 'A Lifetime in Surgery' Lecture to the St George's Surgical Society on the 18th October 2015 – the Barber –

Mr Ian Jenkins in the new Theatre 6, 12th February, 2014

Surgeons Lecture Royal College of Surgeons & Physicians, Glasgow on the 15th April 2016 and a Grand Round on rectal prolapse to Techniques in Coloproctology at St Mark's Hospital on the 23rd September 2016. He contributes two monthly columns to the surgical press in Colorectal Disease (Gemellus) and in The Bulletin of the Royal College of Surgeons of England.

PROF. ROBIN KENNEDY

Professor Robin Kennedy spent a very enjoyable five years working as Dean with Judith Landgrebe and her team and was pleased to hand over the deanery to Sue Clark during this period. This allowed more time to develop clinical research projects such as full thickness laparoendoscopic excision of the colon (FLEX). Adela Brigic's excellent contribution to this research completed and Andy Currie stepped in to take us to new heights, distinguishing himself by the receipt of a Dunhill Medical Trust Research Fellowship award.

April 2014 was the landmark date when we performed the first FLEX procedure in a patient. Thereafter Andy's research output was prodigious and in collaboration with George Malietzis, a formidable team examined many aspects of colorectal neoplasia. Financial support from numerous donors has proved invaluable, led by the inspiring work of the group '40tude'. Collaborations with the Oxford Trials unit, Jane Blazeby, Dion Morton, Ken Fearon, Olle Ljunqvist, Phil Quirke, Nick West, Ronan Cahill and Neil Mortensen were enjoyable and underpinned a diverse clinical research portfolio. The multicentre EnROL trial finished and pointed the way forward to laparoscopic surgery as being the preferred approach, when possible, for colorectal resection. We have become more engaged with complete mesocolic excision and have regularly welcomed Danish consultants for training in this. The output of higher quality videos has been essential to provide the manuals for our teaching and has been a tribute to Steve Preston's expertise and the energy of registrar video editors. Trips to lecture or operate have included visits to Riyadh,

San Antonio, Cleveland, Valencia, Krakow, Aarhus, Paris, Munich, Fort Lauderdale, Naples, Washington, St Gallen and numerous UK locations.

MR IAN JENKINS

Ian Jenkins continued in his role as Lead for Colorectal Cancer and for the Complex Cancer Service. He has continued to teach, perform live demonstration operations and lecture nationally and internationally on minimally invasive colorectal surgery and on surgery for advanced and recurrent colorectal cancer; travelling to Nashville, Shanghai, Chongqing, Tokyo, Malmo, Lyon, Colombo, Sinaia, Timisoara, Cluj, Vienna, Barcelona, Opatja, Lisbon, Porto, Edinburgh, Manchester, Basingstoke, Colchester, Gateshead, and Cambridge. The St Mark's Techniques in Coloproctology Course was started over this time. In addition to the development of novel surgical approaches to resect advanced and recurrent cancer (ELSiE, HiSS), he has been involved in the development of cancer-related studies including the multicentre SAILOR trial assessing the role of radiotherapy in low rectal cancer, Beyond TME trial, PelvEx collaboration and related NICE guidelines, to name a few. Mr Jenkins moved from the Education Committee of United European Gastroenterology (UEG) to the Scientific Committee in 2015 and also joined the UEG Postgraduate Training Programme Committee. He joined the Royal Society of Medicine Coloproctology Section Council, organising an RSM teaching day at St Mark's in 2015: 'Colorectal Cancer and the Host'. His Research Fellow, Mr George Malietzis, was awarded his PhD during this time: 'Body Composition In Relation To Clinical Outcomes and Immune Response in Colorectal Cancer Patients' yielding multiple high impact journal publications to add to the many other journal articles and book chapters generated over this time. George's work will continue with the BiCyCLe study.

Macmillan Colorectal Cancer Nursing Services Annual Report 2015

Executive Summary

This annual report produced by the Macmillan Colorectal Nursing Service reviews the year commencing January 2015 to end December 2015. The report outlines the service delivery, achievements of the nursing service and the proposed service developments.

This has been a successful year for our service with improvements delivered in continuity and coordination of patient care and the development of new patient care pathways. The service has responded to more patient phone calls than ever before this year. 2015 has seen a rapid expansion of the complex colorectal cancer service with patients being referred from all over the UK.

The establishment of two new permanent posts – the Macmillan Nurse Consultant with a 50% clinical colorectal caseload and a full-time Colorectal Nurse Specialist within the team this year has made it possible to meet this increased clinical demand. Our service developments have focused on delivering on the survivorship agenda and we are currently the highest performing Trust for delivery of holistic needs assessments for this patient group across the LCA.

In the forthcoming year we have set several objectives including a desire to achieve a 100% CNS presence at time of diagnosis and assume a greater monitoring role after treatment completion as we implement supported self-management using Infoflex software.

Aims of the Macmillan Colorectal Cancer Nursing Service

Our overall aim is to ensure all colorectal cancer patients referred to the service receive high-quality, patient-centred care by being compassionate, responsive and innovative. Our focus remains on improving patients' experience and satisfaction.

The more specific aims of our service are:

- To improve the outcomes for individuals diagnosed and treated for colorectal cancer by ensuring consistency in service provision
- To act as a key worker from time of diagnosis for patients and their carers throughout their treatment pathway

- To demonstrate key skills in identifying and caring for the specific needs of patients and carers with colorectal cancer providing relief of symptoms, psychological support, information and advice
- To provide specialist nursing interventions to address the consequences of cancer and its treatment
- To promote continuity of care for patients moving across different care settings, overcoming organisational boundaries
- To offer shared decision-making and promote self-management
- To enhance communication across the MDT by supporting patients along their care pathway
- To support the acute oncology service when patients with colorectal cancer access unscheduled /emergency care
- To raise public awareness of bowel cancer and the national bowel cancer screening programme that support the Public Health agenda.
- To continue personal and professional development
- To engage in improving and developing services to create a centre of excellence in colorectal nursing practice, audits and research
- To embed and develop processes for obtaining patient feedback

Macmillan Colorectal CNS Team

This year we managed to successfully secure permanent funding for two new posts; one Clinical Nurse Specialist and one full time Macmillan funded Colorectal Nurse Consultant. Each CNS independently manages their patients' caseload.

- Claire Taylor, Nurse Consultant, Colorectal Cancer/Survivorship, 1 WTE, Band 8c
- Manju Khanna, Macmillan Senior Colorectal CNS, 1 WTE, Band 8a
- Maria Rakova, Macmillan Colorectal CNS, 1 WTE, Band 7
- Sarah Pitcher, Macmillan Colorectal CNS, 1 WTE, Band 7
- Deborah Smith, Colorectal Nurse Specialist, 0.75 WTE, Band 6

What we do

The Macmillan Colorectal Cancer (CRC) CNSs use their skills and expertise

to provide information and emotional support, acting as a patient's key worker from point of diagnosis through treatment so no patient faces cancer alone. We can help in managing their care pathway.

The supportive care and information elements of the role include provision of:

- Support at initial diagnosis
- Individualised information about cancer, its treatment and all consequences
- Holistic needs assessment
- Support with oncology and surgical treatment decision making
- Advice on management of symptoms and treatment side effects
- Telephone support helpline every day Monday to Friday
- Financial assistance and advice including applying for attendance allowance, PIPS allowance, Macmillan grant, DS1500 forms and prescription exemption certificate
- Level 2 psychological support
- Referring and signposting to specialised support services, support groups, GP, stoma care, palliative day care and community palliative team
- Onward referral to other CNS services to follow patient's transfer to specialist cancer centres

Clinical Activities

The Macmillan Colorectal Cancer Nursing Service at London North West hospital (LNWH) NHS Trust was established in 1996. Since this time, the number of patients referred to the service has increased due to the rising population locally, increased incidence of colorectal cancer nationally, roll out of the national bowel cancer screening programme, increased patient expectations, expansion of the complex cancer service and with it greater numbers of tertiary patients being referred to St Mark's.

We set a standard of care in October 2012 to ensure all patients received a comprehensive and equitable service (Appendix 3). Each planned intervention along the patient pathway is either a policy/peer review requirement or has been evidence-based.

The Colorectal Cancer service at LNWH Trust is now one of the busiest services across the London Cancer Alliance with nearly 1000 patients referred urgently (via the two week wait) with suspected lower GI cancer; over 230 patients treated within 31 days (from decision to treat) and 90 patients referred non-urgently and treated within 62 days. As a result our team see more than 250 new cancer patients every year. In addition to this the team see nearly 100 tertiary patients referred for complex cancer care management who have been diagnosed with locally-advanced and recurrent disease, which is discussed in more detail in Appendix 1.

The Colorectal CNS role is multifaceted and offers a range of services to patients being treated in a range of settings across the Trust including the endoscopy, outpatient department and all in-patient wards as demonstrated in Appendix 2. We do not discharge patients and thus patients referred may continue to use the service for years after their cancer diagnosis.

Newly-diagnosed patients

Figure 1 shows a total of 267 new colorectal cancer patients were diagnosed in 2015.

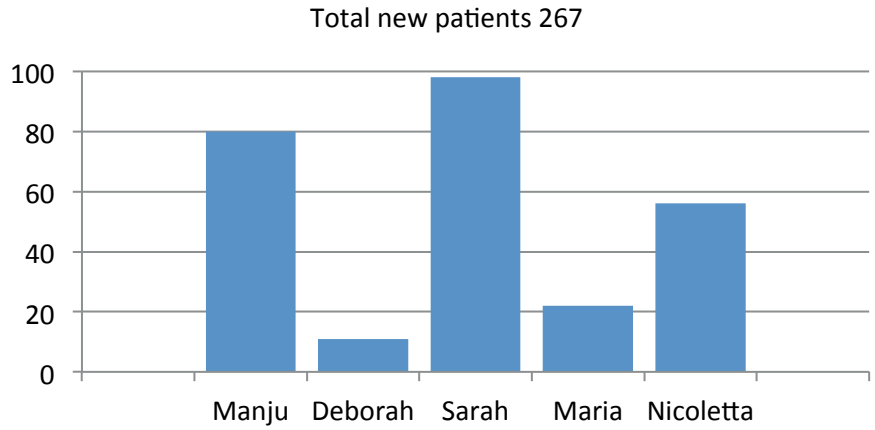


Figure 1: New cancer patients seen by the Clinical Nurse Specialists in 2015

In interpreting the data, the following staff changes should be

highlighted: Nicoletta left at the end of June and Deborah started the beginning of September 2015.

A census of CNS caseload across the UK in 2014 indicated that the mean number was 85 new patients referred on average.

Number of interventions

Once treatment is completed, we do not discharge patients and offer on-going support meaning patients may be on our caseload for up to five years. Each month we support over 150 different patients (follow-up and new) through our service. Table 1 illustrates the total and types of significant interventions from 2011 to 2015. The data has been drawn from a review of our recorded GCIS activity; we have termed this as significant intervention as we take many patient phone calls and give clinical advice which is not recorded. This data clearly demonstrates our total interventions in OPD, wards and via telephone support have increased over the last three years.

Year	*New patients referred*	*Significant interactions*	*OPD*	*Phone*	*Ward*	*Other*
Sept. 2011–2012 12 month period	241	1508 in 12 months	492	617	262	
Sept. 2012–August 2013 11 month period	329	2417 in 11 months	694	1258	319	146
April 2015–Sept. 2015 6 month period	177	2777 in 6 months	335	2268	175	

Table 1: No of CNS recorded patient interventions 2011–2015

The total number of interventions carried out by each member of the team is presented below in Table 2.

Postholder	*MK*	*MR*	*SP*	*DS*	*NS*	*CT*	*Total*
Total number of GCIS interventions 2015	1439	530	1207	342	899	2152	6569

Table 2: Total number of GCIS interventions 2015

MK (Manju Khanna), MR (Maria Rakova), SP (Sarah Pitcher), DS (Deborah Smith), NS (Nicoletta Spanache), CT (Claire Taylor)

Complexity of caseload

We have observed an increase in the complexity of our caseload and we would like to highlight some characteristics of the patients referred to the service. In examining the age range of the patients newly diagnosed with colorectal cancer referred, Figure 2 shows that 13% (35 patients) were less than 50 years of age. This year we have noted that a large number of these younger patients were diagnosed with advanced disease and as a result they often have complex physical symptoms and a range of psychological, financial and occupational needs. These patients have required much support from our service across their care pathway.

At the other end of the age range, we have seen 58 new cancer patients who were within 81–90+ age group (22% of all patients referred). These patients are more likely to have multiple co-morbidities, be living alone and have a longer in-patient stay and as a result complex discharge care needs. This patient group are more likely to need our input in optimising their health prior to treatment by coordinating their assessments prior to surgery such as an anaesthetic review as well as more careful monitoring after treatment. Due to their performance status and overall health, more of this patient group are treated with palliative intent and require greater support to help them manage at home.

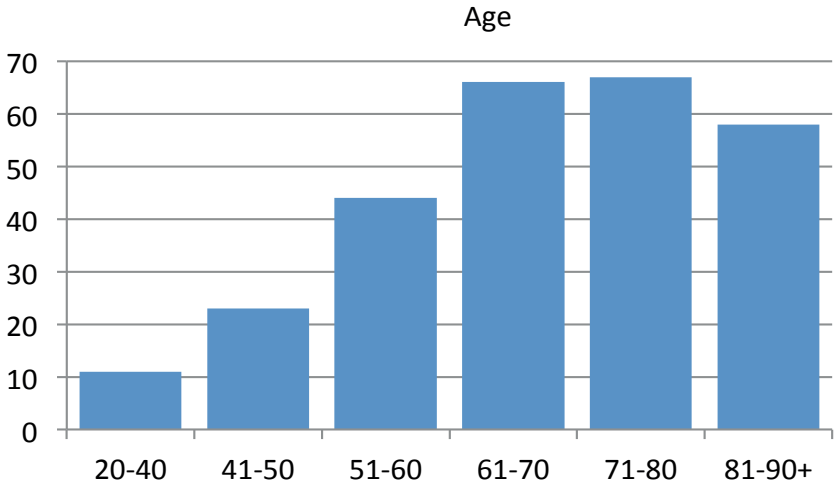


Figure 2: Age distribution of newly diagnosed patients referred to the service

Of the 268 patients referred, 151 were male and 116 patients were female which is reflective of the national male:female ratio of 13:10 (CRUK data). Patients diagnosed with left-sided colorectal cancer may require a high level of support because treatment decision-making can be more involved and there may be need for the formation of a temporary or permanent stoma (see Figure 4).

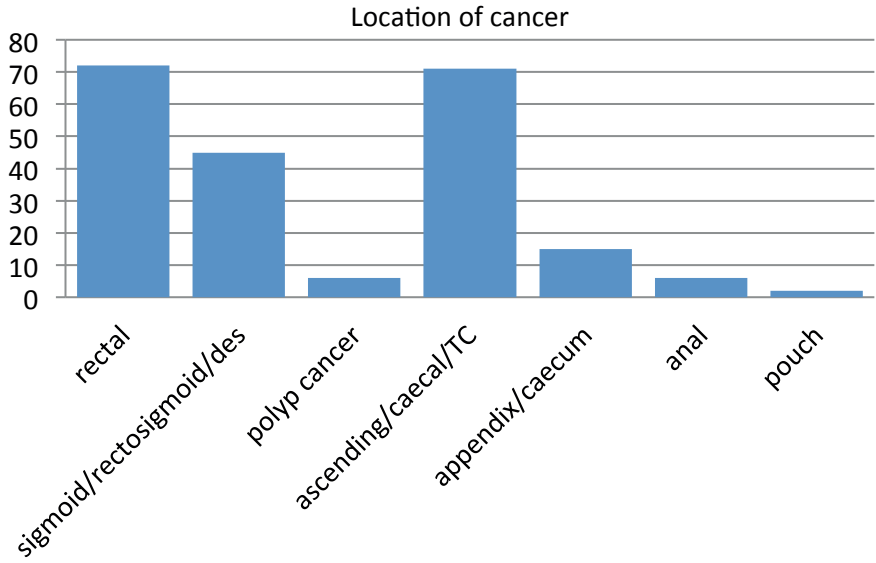


Figure 3: Numbers of colorectal and anal cancer of patients referred

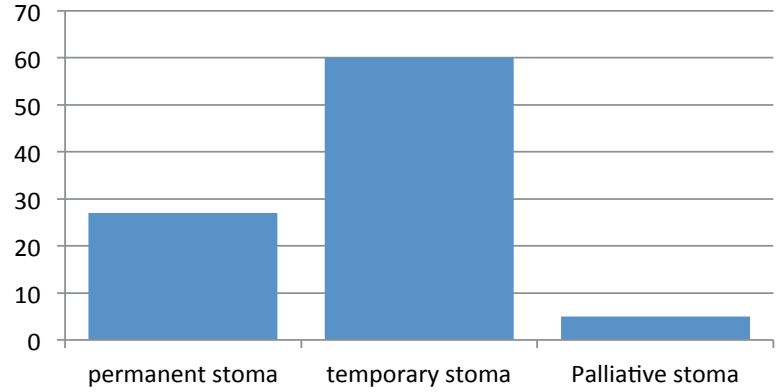


Figure 4: Number of patients who had new stomas formed in 2015

Formation of stoma in colorectal cancer patients can have significant impact on their sexuality, body image, diet, psychology and life style. In 2015 we supported 27 patients with permanent stomas, 60 patients with temporary stomas and 5 patients who had a Hartmann's procedure. We introduce patients to the stoma care nursing team so they can be psychologically prepared/sited pre-surgery without delay. However since we meet patients at diagnosis, we address their initial anxieties about stomas until the stoma team sees them.

We are involved in supporting patients through the management of many complex cancer pathways and this can necessitate much liaison with other service providers whilst also keeping the patient updated.

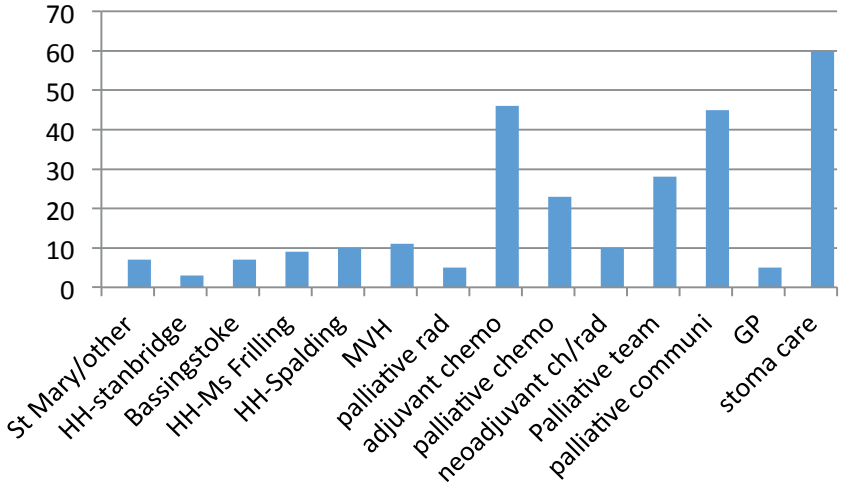


Figure 5: Referral to other support services and treatment centres

Our records indicate that in 2015:

- 46 patients were referred to the chemotherapy unit for adjuvant chemotherapy
- 23 patients for palliative chemotherapy
- 10 patients to Mount Vernon Hospital for neo-adjuvant chemo radiotherapy
- 5 patients had palliative radiotherapy
- 7 patients were referred to St Mary's Hospital for anal cancer treatment

- 7 patients were referred to Basingstoke Hospital with a peritoneal malignancy
- 3 patients were referred to Mr Stanbridge at Hammersmith Hospital for the management of a metastatic lung lesion
- 9 patients were referred to Professor Andrea Frilling for neuroendocrine tumour management
- 10 patients were referred to Mr Spalding with metastatic liver disease
- 45 patients were referred to the specialist palliative care community team for psychological and symptoms support
- 60 patients were referred to the stoma care team
- Several patients were referred to the Macmillan information centre for financial benefit advice and a Macmillan grant
- Many patients were referred to a dietician and GP for prescription, symptoms support and nutrition advice

Colorectal CNSs run a very busy telephone support helpline Monday to Friday 8:30am–4:30pm. Figure 6 shows we received approximately sixteen phone calls per day. This year, our service has responded to more patient phone calls than ever before which we believe partly reflects a better level of engagement with those referred but is also a response to patients' difficulties in overcoming delays in the system due to overwhelming demand on clinic appointments, radiology and theatre capacity.

Figure 7 show we received 4000 telephone calls in year 2015, compared to 2500 phone calls in 2014. This is an increase by 1500 more telephone interventions within a year.

Our recent two-week telephone audit in November 2015 indicated that most of our telephone interventions were level 2 and 3. They were usually calls from patients for the following reasons:

- To find out there surveillance pathway and/or check CT or MRI appointments
- For advice, emotional and symptom support
- To discuss their blood, CT or MRI scans results
- To find out their outpatient clinic date, or to know their pre-assessment/surgery date

We also received calls from MDT co-ordinators to help monitor patients' pathways or breech dates. Junior doctors or ward nurses often call us for information about the patients or to know their pathway or oncology treatment plans.

These calls usually result in us making further telephone calls or sending emails to relevant consultant surgeons/oncologists/registrars/OPD manager/ radiology or MDT co-ordinators.

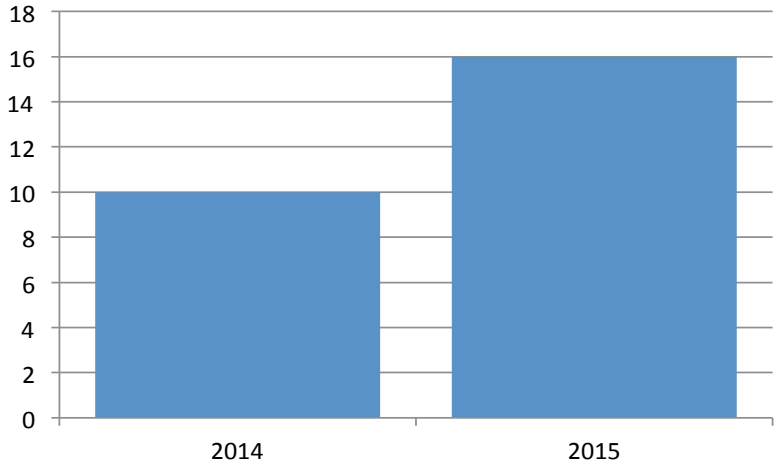


Figure 6: Average telephone calls per day

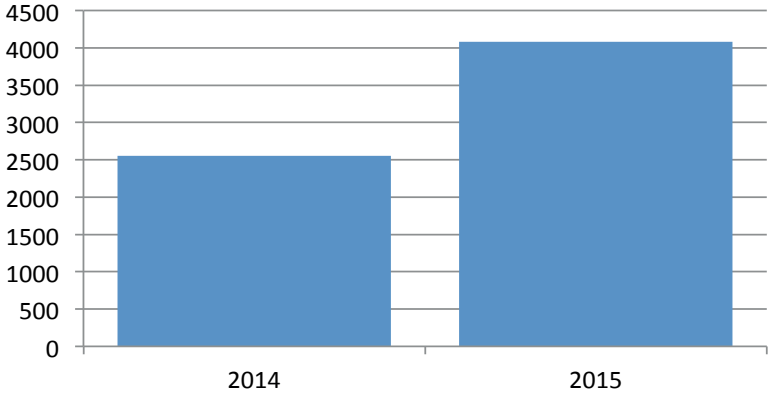


Figure 7: Telephone calls in 2014 and 2015

Through the national patient experience survey, patients welcomed the CNS contribution, particularly continuity of care, vigilance and rapid access for specialist advice via telephone support. If patients did not have

access to specialist nursing advice on the telephone, they would have requested either a GP or hospital appointment or would have attended the accident and emergency department. The average cost for a GP appointment is £60 (National Audit Office, 2009). The CNS plays a pivotal role in ensuring safety and high quality care, essentially for patients managed in the community or when they are referred to other treatment centres to receive specialised care.

Key performance indicators

There are four main key performance indicators for the CNS role that are monitored externally:

1. Being present at time of diagnosis
2. Completion of Holistic Needs Assessment (HNA)
3. Attendance at health and wellbeing and survivorship events
4. Entering patients into supported self-management

These shall be addressed in turn:

1. Being present at time of diagnosis

Management of anxiety and distress is a prime role of the CNS and much of this distress is caused by a new diagnosis, a perceived future loss of function and biological disruption as well as fear of the unknown in terms of effect and risks of the surgical and oncological treatment. Others are alleviation of physical and psychological suffering through assessment and specialist symptom management, assessing and meeting information needs, acting as an accessible, knowledgeable professional and brokering rapid access to other professionals.

St Mark's Hospital is a bowel cancer screening hub and bowel scope screening centre. In 2015, 53 patients with bowel cancer were diagnosed through the screening programme and we have a close working relationship with the bowel screening nurse practitioners to facilitate a smooth transfer from their service into a treatment pathway. They alert us to patients who they suspect may have colorectal cancer.

We now meet most patients with suspected colorectal cancer when they are first informed of their diagnosis in the endoscopy department.

Figure 8 shows that more than 180 patients were referred through the OPD, 41 patients were given the diagnosis of cancer in wards and around 38 patients were told of their diagnosis in the endoscopy department.

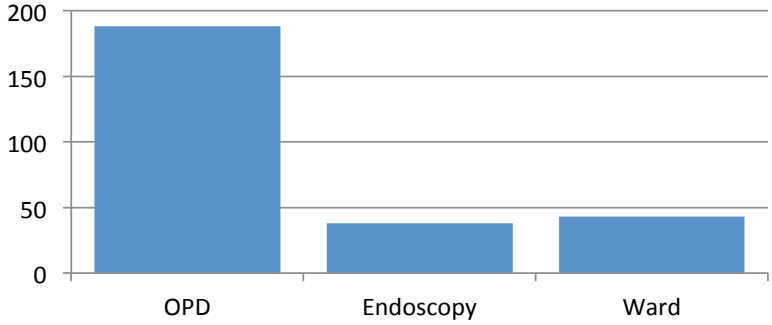


Figure 8: Source of new referral to colorectal nursing services

We have over ten consultant clinics where a patient may be given the diagnosis each day. Figure 9 reveals the number of new cancer patients seen by a consultant.

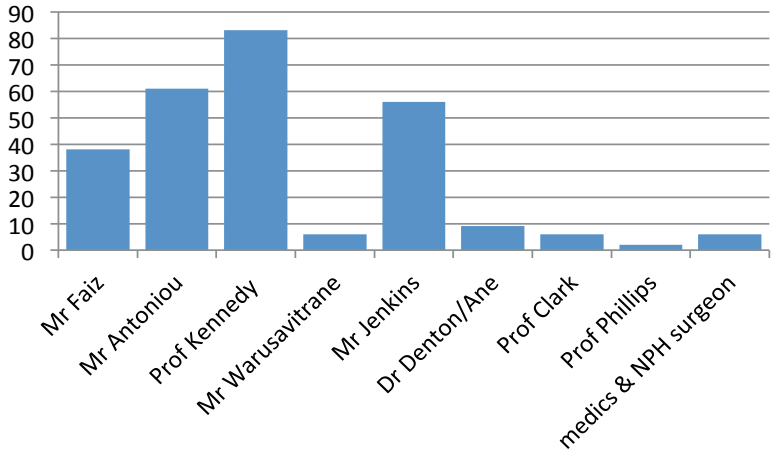


Figure 9: New cancer patients seen by consultants

In 2015, 86% of the new cancer patients were seen on diagnosis and 14% of patients were not seen because of their emergency admissions or the CNS was not called when breaking the news to the patient as presented in Figure 10.

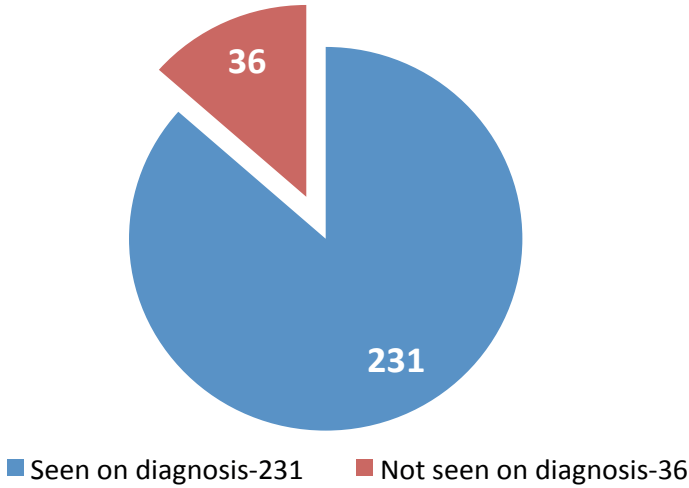


Figure 10: Patient seen on diagnosis/not seen on diagnosis

2. Completion of a Holistic Needs Assessment (HNA)

Following on from the success of the National Cancer Survivorship Initiative, the Living With and Beyond Cancer (LWBC) Programme, led by Macmillan, have advocated that all cancer patients have access to holistic needs assessment, treatment summary, cancer care review and a patient education and support event called the Recovery Package. This was endorsed by the London Cancer Alliance and quarterly targets were set for each aspect of the recovery package during 2015, against which our activity is measured.

We introduced Holistic needs assessments into our service in March 2013. This year we formalised this specialist nursing activity within each patient's pathway of care by providing written information, booking patients in for a holistic need assessment with us at the two set time points and the offer of doing so as part of a nurse-led telephone clinic (code: NPONCO15CT). We are proud to say that in 2015 the Colorectal CNS completed the highest number of HNAs for their patients when compared to other site-specific nursing services in the Trust. In 2015 we completed 99 HNA within 31 days of diagnosis, which means that we are the second highest performing Trust in this aspect across the LCA. Whilst half of patients did undertake an HCA, we didn't quite meet the target they set of 60%.

After treatment we completed 87 HNAs with patients within six weeks of treatment, which meant that we were the highest performing Trust in this aspect across the LCA and we did meet the target set of 60%.

3. Health and well-being and survivorship events

We ran four health and well-being events in 2015 and 25 of our patients attended one or more of these. This is under the LCA target of 60% of patients, which we are expected to achieve. We did spend many hours marketing these events; sending out over 70 personal invites and phoning many who had expressed an interest to encourage their attendance. However on the day many did not attend.

4. Entering patients into supported self-management

Self-management support involves health professionals, teams and services working in ways to ensure that people with cancer (or indeed any long-term condition) have the knowledge, skills, confidence and support they need to manage their condition(s) effectively in the context of their everyday life. To offer effective self-management support, changes are required at every level. In colorectal cancer we made an early start in this respect by introducing health and wellbeing events and survivorship events which help to achieve these aims. We also piloted a new system of follow-up care which involves a stratification process to ensure that the care pathway after treatment is most suitable for each patient, based on the level of care needed for the disease, the treatment and the patient's ability to manage, and therefore dictating what level of professional involvement will be required. Those with low risk disease who are able to self-manage can be supported to enter remote surveillance and with nurse-led telephone support can avoid a need to return to the hospital for an out-patient review.

We delayed rolling out our successful pilot until we had a robust monitoring tool to track each patient's surveillance. The Trust acquired Infoflex Spring 2015 but there has been delay in its development and it has yet to go live. As a result, all patients continue to receive traditional follow-up and continue to be seen in the out-patient clinic.

Colorectal Cancer Nursing Service efficiency gains and evidence of the impact of the service

In order to meet national and local Trust targets and peer review standards, we monitor patient care and intervene as needed during their care pathway to ensure high standards of patient care are achieved. Evidence that we are improving patients' experience is anecdotally noted every day in our feedback from patients. We believe we reduce patients' complaints by offering a person-centred service and taking time to hear their concerns and address them. To improve communication and in line with technological advancement and patients demand we have introduced a novel generic email support helpline (LNWH-tr.MacmillanColorectalCNS@nhs.net) that has been currently supporting a number of patients. These patients are either working, live far away or prefer to communicate via email.

The colorectal cancer diagnostic and treatment pathway varies considerably for each patient and involves the whole multidisciplinary, with whom we work very closely. For most patients we will be liaising with gastroenterologists, surgeons and oncologists as well as many other allied health care professionals and members of the primary care team. Our communication helps keeps the patient central in all our treatment decision-making since we come to know most patients well. After the Colorectal Cancer MDT each Friday, we spend a great amount of time addressing and communicating the meeting's recommendations about each patient – which can be up to 30 patients a week. This involves phoning patients to inform them of the next steps in their care whether this is to attend to clinic, to have another investigation or to remain on agreed care/monitoring pathway. Our interventions often avoid the need for the patient to come to clinic to receive new information discussed in this meeting e.g. a scan result. We have also introduced a new system of checking all MDT requested OPD appointments with the MDT co-ordinator and booking clerk after each MDT to prevent omissions. We then check that all these appointments are made and that the patient is informed of them (as they often are not notified in time, if at all due to sheer pressure on the system and administrative shortages).

Below we list a few examples of how we have improved efficiency in the patient pathway:

1. The patient is seen in the endoscopy department and the CNS ensures scans are expedited; MDT is arranged and timely management of their cancer pathway to avoid breech and support patients with their anxiety until they are seen in the clinic. Blood test repeated for very low HB patients. If HB is reported extremely low CNS contacts the GP to arrange blood transfusion or direct admission to ambulatory care after discussion with the team if known to hospital consultant.

2. New cancer patient DNA clinic appointment. Next appointment sent in few months. CNS looks at the DNA patient's lists and contacts the patient. The CNS expedites the clinic appointment to avoid breech and symptoms deterioration while waiting.

3. Phone call to the patient for post-op HNA. Patient is not feeling well. Bring forward clinic appointment to prevent further deterioration and complications that saves money in the long term if patient had to be admitted in emergency. CNS sometimes asks them to come to chemo unit for assessment by the acute oncology consultant or to A&E for urgent assessment and investigations that minimises symptoms, deterioration and HDU admissions.

4. Patient on chemotherapy calls in that they are not well. Symptoms support and advise. Contact chemo for urgent assessment and may be to cancel planned treatment, so the chemo slots can be offered to other patient on waiting. This also avoids chemo wastage and Trust money.

5. Palliative patient phones in that they are not well and if they need to come to the hospital. CNS gives symptoms advice/treatment change. Refers them to the GP or to the palliative community team for symptoms assessment and support that avoids unnecessary hospitalisation.

6. Patient had surveillance CT and has outpatient appointment in few months. Patient calls in for the report. If all satisfactory she will discuss the results with consultant and will arrange future surveillance investigations. Outpatient appointment will be cancelled and rescheduled after next surveillance. This saves clinic slot that can be offered to more urgent patient.

7. Patient had surveillance CT that reported disease recurrence. Patient calls in for the report. CNS arranges MDT discussion and expedites clinic

appointment to avoid delay in starting treatment.

8. Patient lost in surveillance pathway. CNS discusses it with the patient and the team. Reinstate surveillance pathway that enhances patient's experience in long run.

9. Palliative patient very unwell and been in the hospital for many days. Refer them to continuing care pathway or to palliative care for fast track discharge planning in nursing home/hospice/home to clear hospital bed.

10. On colorectal cancer surveillance CT patient is found to have suspected lung nodule. CNS arranges referral letter to lung MDT and presents the patient in the lung MDT. Lung MDT outcome – patient to have lung function test and to refer patient directly to Mr Stanbridge for lung wedge resection. CNS arranges urgent lung function and referral letter to Mr Stanbridge in Hammersmith. Liaises with the patient and his family for the update. She also liaises with the CNS in Hammersmith Hospital for the update and arranges patient OPA. She than contacts the service manager to cancel the surgical clinic outpatient appointment with the surgical consultant for the following week as there is no need to waste patient and consultant time.

11. We have developed new pathways aimed at improving continuity of care and ensuring timely referrals to other support providers including the stoma care team, chemotherapy, palliative community day care and the palliative community team. We now liaise directly with the CNS and MDT in the HPB team at the Hammersmith Hospital, lung CNS for lung metastasis surgery and peritoneal malignancy CNS at Basingstoke Hospital when our patients are referred there for opinion/treatments which speeds up the referral pathway. A pathway is introduced (Appendix 3) which can be time consuming, however it has proven to be very effective and improved patient experience and outcomes.

Professional activities

1. Teaching on level 5, 6 and 7 degree-modules on both Colorectal Cancer and Stoma Nursing courses by senior CNS and Nurse Consultant which are accredited by Birmingham University and are run locally at least twice a year.

2. Teaching on the endoscopy assistance course twice a year.

3. We run bespoke teaching on the wards and give updates in the chemotherapy suite and out-patient departments twice a year.

4. In bowel cancer awareness month we run health promotion events.

5. Recruiting and running health and well-being events.

6. Orientation day for new recruit in bowel cancer screening to promote Macmillan role.

7. Appearance on national television to raise awareness to Macmillan's work.

8. We are members of the RCN and UKONS.

9. Senior CNS has been involved with Bowel Cancer UK information review and also Delphi study that identifies future research opportunities for nurses.

10. CNS Maria Rakova is Chair of the Nursing Chapter of the ACPGBI and helps with Delphi research and innovation exercise.

11. All CNS have attended at least two days of external education to ensure they remain up to date in their specialist practice.

Future opportunities/objectives

1. We are keen to achieve a 100% target of being present at time of diagnosis and we believe that to do so we have to focus on patients diagnosed along the emergency pathway. The LCA estimate that 28% of patients in NW London are diagnosed following emergency admission which would suggest that we are missing some patients who are treated for their cancer following this admission. We have discussed how we might achieve this with the Service Lead in the past but it has proved difficult since many different professionals are involved in their emergency care pathway and there may be uncertainty of the diagnosis until post-operative histology is reported which is often after the patient has been discharged.

2. We are keen to meet the LCA targets set for completion of HNA and care plan at the two time points. In the forthcoming year we wish to introduce more patients to electronic HNA (e-HNA) in addition to continuing to offer our usual HNA service. There are two reasons for this. The first is that e-HNA can be undertaken from a patient's home if the patient has a smart phone or laptop, providing them with more flexibility and control over this process than us leading the HNA with use of our own electronic solution which we currently directly enter on to GCIS. Secondly e-HNA does allow better audit of patient concerns and care plan requirements.

3. We hope we can move forward with supporting more patients to self-manage once Infoflex (the monitoring tool to track each patient's surveillance) is fully developed and the Trust agrees to re-employ a support worker to assist with the administration which goes with entering 100+ patients on to remote monitoring follow-up after treatment. To help embed this we need to be properly remunerated for such activity and these services need to be properly commissioned, as there are significant implications for nursing resource and impact on our service. The high administrative load we currently carry will only increase and we do need to have a support worker in our service if we are to work to our maximum efficiency.

4. Two new services are being introduced in St Mark's, which will play an important role in developing and maintaining patients with colorectal cancer.

a) The first of which is the development of a closer to home neuroendocrine cancer service for patients diagnosed with neuroendocrine cancer in this Trust through a collaboration with Hammersmith Hospital.

b) The second is the establishment of the Hyper thermic Interaperitoneal Chemotherapy (HIPEC) service being introduced in collaboration with Basingstoke to support patients diagnosed with psudomyxoma peritoneal malignancy.

5. Following our merger, we have yet to fully integrate and standardise the colorectal cancer service. There is a need for a Trust-wide service delivery model, which encompasses Ealing Hospital to improve equity

and efficiency. As part of this we envisage new patient pathways and a need to revisit and refine the CNS service contribution within this.

Summary

CNS has become an integral and vital part of the multidisciplinary team, is valued by patients and represents an excellent return on investment, in terms of clinical activities, patient safety, support, education and research. CNS work has included leadership roles and service redesign; however CNS interventions are not coded and fail to describe the breadth of complex hidden work that a CNS performs.

In the national patient experience survey, patients valued the additional information, education and support that CNS provides. CNS activities required specialist knowledge and assessment skills to enhance self-management principles and manage unresolved symptoms that cannot be carried out by the administrator, secretary or a junior nurse.

The footfall of colorectal cancer patients in this Trust is growing and we need to maximise our ability to provide high quality patient care. We pride ourselves on offering a patient-centered approach which provides patients with compassion, continuity, skilled communication and co-ordination along their individual pathway to ultimately enhance their care experience. As a team we will continue to strive to further develop our service to further improve outcomes for those living with and beyond cancer.

Appendix 1 – Claire Taylor's summary of her annual report

The Macmillan nurse consultant post was a new role in the Trust, funded by Macmillan to lead the development of colorectal cancer nursing by managing a team of clinical nurse specialists. Supported by the Trust Lead Cancer Nurse it was also envisaged that the post-holder would play a key role in the initiation, implementation and sustainability of cancer survivorship/recovery package for patients across London North West Healthcare for both oncology and haematology patients.

Claire Taylor was appointed on the 1st April 2015. Claire had been a Senior Clinical Nurse Specialist in the Trust since September 2012 and had also worked in the service from 1996–2002 when she established

the Macmillan Colorectal Cancer Nursing service. This was her first nurse consultant post.

Approximately half the time of nurse consultants (NC) is spent in direct clinical practice with the role focussing on four patient groups:

1. Individuals with complex colorectal cancer (CCC) who are referred from across the UK.

2. Those experiencing GI consequences of cancer – a new service we launched on May 1st 2015.

3. People previously referred to the Macmillan colorectal cancer nursing service.

4. Survivorship activities for any patient treated in the Trust living with and beyond cancer.

During the first year in post, the NC saw 213 different patients of which 101 were new patients.

Complex colorectal cancer new patients	83
Complex colorectal cancer follow-up patients	79
GI consequences service new patients	18
Patients in the Macmillan CRC CNS service	22
Follow-up patients from pilot	11
Total number of patients	213

During this time period the NC carried out 1789 different interventions, the majority of which were conducted over the phone reflecting the fact that the majority of them were complex colorectal cancer patients.

Number of phone interventions	1286
Number of patients seen in OPD	191
Number of ward visits	184
Number of emails	128
Total interventions April 2015 to March 2016	1789

The survivorship clinical work consisted on planning and delivering four health and well-being events, two survivorship programmes, one survivorship follow-up day and one taster day.

Service development

- Support to the nursing team in developing survivorship activity involving running 3 HNA educational events and reminder emails. Collation and reporting of Trust's quarterly survivorship metrics and also bimonthly submission of e-HNA activity
- Led a launch event of the GI consequences service here at St Mark's to which we invited regional leads in gastroenterology and oncology. We also ran a lunchtime educational event for local GPs
- Survivorship workshop for local GPs to introduce the Recovery Package
- Survivorship development within the LCA colorectal pathway includes two clinical fora presentations, led on treatment summary and health and well-being event guidance

Academic activity

- Five national conference/study day presentations
- Three teaching sessions on degree-module courses
- Lead author on three national peer-reviewed publications and second author on another
- Development and presentation of two conference posters
- One international workshop for EONS. One regional presentation for ACPGBI Wessex
- Co-applicant on two successful charitable grants: Burdett Trust £250,000 over three years, London North West Healthcare Charitable Foundation £20,000

Leadership role

- Chair of National Colorectal Cancer Nursing Network which involves leading 300 CRC CNS, producing regular member newsletters, and organising a national conference
- LCA Survivorship Pathway group member and led on three documents: guidance on Health and Wellbeing events, consequences of cancer position statement and three HNA fact sheets

- Faculty member of SPECC – Significant Polyp and Early Colorectal Cancer and led on the production of patient information
- Consequences of Cancer collaborative member
- EONS member and lower GI oncology representative
- Cancer Nursing Partnership member
- Reviewed NICE guidance for RCN

Other highlights

- Led on development of national guidance to manage consequences of CRC cancer
- Finalists in the QIC Oncology national awards for collaboration on cancer care category. The award submission was written by Claire Taylor
- Attendance at a professional workshop aimed at agreeing strategic priorities for the Cancer Taskforce and then contribution to two formal responses to the published strategy on behalf of nursing organisations in order to promote cancer survivorship
- Lead author on the publication of two Coloplast educational resources – a toolkit for patients and also one for health care professionals on managing anterior resection syndrome, which are now in national circulation
- Overseeing development and leading evaluation of the Burdett scholar three year programme

Appendix 2 – Job plan example

Senior Macmillan Colorectal Clinical Nurse Specialist: colorectal; name: Manju Khanna, date: December 2015:

a) Timetable of activities which have a specific location and time (e.g. 0800–1600 Monday–Friday):

Day and time	*Location*	*Type of work*	*Additional detail*	*Est. number of patients reviewed*
Morning	Dr Denton, oncology clinic	NPH Clinic	Adjuvant chemo discussion Palliative chemo discussion New or follow up patients	0–5
	GCIS update	Office	Service development: patient information	0–5
	Admin	Office	Phone calls/answer phone, emails, audit, prepping clinics	
Afternoon develop-ment, improve-ment	Dr Anyamene, oncology clinic	NPH Clinic	Telephone HNA	
	Cover for Deborah Smith-D/Off		Adjuvant chemo discussion Palliative chemo discussion	
	Cover for Maria Rakova-D/off		New or follow up patients	
	Admin Service development/ improvement	Office	Telephone calls Answer phone Emails, prepping clinic, clinical supervision, audit, telephone HNA clinic and GCIS update	1–8
	Mr Jenkins' surgical clinic	St Mark's clinic	New cancer patient-colorectal/ anal cancer Follow-up: cancer surveillance Follow-up: palliative Follow-up: post-operatively Stoma reversal discussion Post stoma reversal	

Day and time	*Location*	*Type of work*	*Additional detail*	*Est. number of patients reviewed*
Wed 0900–1300	Mr Faiz surgical clinic	St Mark's clinic	New cancer patient-colon cancer, carcinoids, peritoneal malignancy, endocrine Follow-up: cancer surveillance Follow-up: palliative Follow-up: post operatively Stoma reversal discussion Post stoma reversal Follow-up patients referred to other hospitals – Hammersmith, Basingstoke, St Mary's etc.	1–8
1000–1030	Dr Denton oncology team meeting	Office	Going through oncology patients currently on treatment	
	Team meeting	Office		
1330–1400	Telephone support	Office	Phone calls/answer phone, emails and GCIS update	
Thurs 0900	Anal MDT	MDT room		1–3
0900–1300	Prof Kennedy surgical clinic	St Mark's Clinic	New cancer patient Follow up –cancer surveillance Follow up-palliative Follow up – post operatively Stoma reversal discussion Post stoma reversal, follow DNA patients, phone calls/answer phone, emails and GCIS update	1–10
1400–1800	Mr Antoniou surgical clinic	St Mark's clinic	Same as above	1–8

Day and time	*Location*	*Type of work*	*Additional detail*	*Est. number of patients reviewed*
Friday 0900–1100	Colorectal MDT	MDT Meeting room	MDT discussion of all new patients and patients with changes in treatment or new pathology/ imaging results/complex patients.	25–30
	Cover for Sarah Pitcher-D/off	Ward, endoscopy	Ward follow-up, endoscopy. Phone calls/answer phone, emails, ensuring information pack in place, update notice board.	0–5
1200–1230	Dr Anyamene oncology meet (weekly)		Going through oncology patients currently on treatment.	
1200–1700			Ward visits and phone calls. MDT follow-through.	

b) Additional activities (internal/external):

Type of work	*Additional detail*	*Frequency*	*Session usually taken*
Training	Mandatory training–personal and staff	Monthly	
Admin	MAP/annual leave/sick leave/return to work	Monthly	
	In-house training and education events Frontiers, Complex cancer study day		
Admin	Peer review preparation: annual report, work plan, operational policy	Annual	
Training/ Leadership	Bowel cancer raising awareness month	Annual	April
Meeting	Senior cancer nurses meeting–sharing best practice, NPH and St Mark's.	Monthly	Monthly
Meeting	Operational meeting/team meeting LCA meeting.	Monthly	Monthly
Meeting	Staff appraisal My appraisal	Annual Annual	
Supervision	Clinical supervision	Monthly	Monthly

Type of work	*Additional detail*	*Frequency*	*Session usually taken*
Meeting	NCCNN conference	Annual	External
Training	Teaching on stoma care course, induction for new nurses in St Mark's	6–monthly	External
Admin	Promotion: survivorship, health and well-being events	As needed	
Leadership	Handling complaints/Datix; Delphi study; information review for beating bowel cancer	As needed	

Appendix 3 – standard of care

Provide a high standard of practice and care at all times when supporting colorectal cancer patients.

Assess the patient holistically:

- You must conduct a comprehensive holistic needs assessment within six weeks of the patient's diagnosis (on receiving a referral)
- You must show evidence of how this assessment has led to individualised care planning
- You should conduct a comprehensive holistic needs assessment within six weeks of the patient finishing treatment

Offer the patient an information prescription:

- You must conduct an individual assessment of information need at key points along the pathway as detailed in the LCA information policy
- You must offer patients the core information pack at time of diagnosis
- You must offer patients the core information pack on completing treatment

Offer the patient a specialist level of support along the care pathway according to need:

- You should offer the patient support according to the Macmillan Colorectal cancer care pathway through both face-to-face interventions and telephone follow-up

- You should make it clear to the patient when you are their key worker and when you are no longer their main point of contact
- You should signpost the patient to appropriate services along the pathway

Use the best available evidence:

- You must deliver care based on the best available evidence or best practice
- You should ensure any advice you give is evidence-based
- You should seek the advice of experts where no evidence exists

Keep clear and accurate records:

- You must complete a paper referral form on first consultation with a new patient
- You must keep clear and accurate records of the discussions you have, the assessments you make and planned care
- You must complete GCIS records as soon as possible after an intervention has occurred whether this has taken place by phone, or face-to-face
- You must ensure any entries you make in the electronic records are clearly attributable to you by entering your name, designation, date and time
- You must record your intervention in the patient's medical notes when visiting in-patients
- You must ensure any entries you make in the patient's medical notes are clearly and legibly signed, dated and timed
- You must ensure all records are kept securely
- Keep your skills and knowledge up-to-date
- You must have the knowledge and skills for safe and effective practice
- You must recognise and work within the limits of your competence
- You should take part in appropriate learning and practice activities that maintain and develop your competence and performance

Appendix 4 – holistic needs assessment pathway

Colorectal Holistic Needs Assessment – Telephone Clinic Pathway

1. See patient at time of diagnosis; introduce concept of HNA; give core information pack which includes written explanation of HNA
2. Gain verbal consent to phone in the next two weeks to conduct HNA or give patient the HNA invitation letter and decide on a date and time when you will call and/or book into the telephone clinic NPONCO15CT and print them an appointment letter
3. Call patient and conduct HNA. Complete care plan; generate letter if required; send the patient a copy of the care plan if needed
4. Open ICS, create referral for the patient; book on to the relevant clinic; attend and discharge the patient
5. Optional record in assessment on GCIS that you had a phone contact with the patient; record in Excel spreadsheet that HNA conducted

Appendix 5 - pathway of care when transferring patients to other centres

1. Colorectal pathway for patients who are referred to other centres for treatment or advice
2. See patient in the clinic. Gain verbal consent to phone in the next two weeks
3. Email or phone call to secretary to type the clinic letter and ask them to fax it urgently with blood test, histology and scans report to referring centre
4. Phone call to the patient in two weeks to check if they received the appointment and give patient contact number for local CNS/ secretary/MDT co-ordinator
5. MDT co-ordinator to send scans via IPED
6. Contact CNS/MDT co-ordinator/secretary via phone or email for transfer of care
7. Follow up phone call in eight weeks to check the progress or to ensure care is transferred back to our centre
8. Record on GCIS and in Excel spreadsheet

Claire Taylor, Nurse Consultant, Colorectal Cancer/Survivorship, 2nd May 2014

St Mark's Association

A message to attendees

It is a great honour to be President of the St Mark's Association this year. The Association meets just once a year for a dinner and a meeting which I very much hope you can attend in 2014. When I joined St Mark's as the medical registrar I was aware of the reputation of the hospital but had no inkling of the lasting impact it would have on me as a clinician, a teacher, and as a person. It is not an exaggeration to say that it was the most intense period of learning I have had in my career. It has also provided me with many longstanding and rewarding professional relationships.

My career since St Mark's has taken an interesting path which has enabled me to work with some fantastic people, many of whom are St Mark's alumni. The programme I have put together for the St Mark's Association meeting includes many of these stars and it reflects my interests and work.

The programme starts with State of the Art lectures on screening and diagnostics, which pose some potentially uncomfortable challenges for those who are happy with the status quo. We then move on to therapy at the boundaries of endoscopy and surgery, and explore the potential for animal models to enable optimisation of new surgical techniques before they are applied to humans. The pre-lunch stimulant, to keep everyone awake, confronts head-on the contentious issue of publishing individual surgical outcome data. This will take the form of a debate delivered by past presidents of the Association of Coloproctology: two seasoned and very accomplished communicators.

We finish off the day setting the scene for my presidential address with presentations on quality assurance, safety, training, leadership and collaboration. In my presidential address I will explain why these things are so critical for overcoming the challenge of delivering effective health care in the context of rising demand, better and more expensive treatments and limited resource.

I very much hope you can join us at St Mark's on the 3rd October 2014 for what will be a very entertaining and informative day. If you can be at the dinner the night before at the Old Etonian I can guarantee you will have a very enjoyable evening with excellent food and wine, and most engaging company.

Roland Valori President, St Mark's Association 2014

St Mark's Association Annual Meeting

3rd October 2014, St Mark's Hospital

"Improving outcomes of bowel cancer. We are doing well but can we be the best?"

Session 1: Optimising diagnosis to achieve better value and improved outcomes Chair: Ian Jenkins		
0930	Optimising patient-centred lower GI pathways	Sarah Mills
0945	England leads the world in bowel cancer screening	Stephen Halloran
1000	The rightful place of CTC in the diagnosis of colorectal neoplasia	David Burling
1015	Colonoscopy is good but not perfect	James East
1030	Panel Questions	
1045 – 1115	Coffee	
Session 2: Pushing the boundaries of treatment by reducing variation and introducing new techniques Chair: Arun Gupta		
1115	Quality metrics for and optimisation of polypectomy	Siwan Thomas-Gibson
1130	Blurring the boundaries of endoscopy and surgery	Brian Saunders and Janindra Warusavitarne
1150	The FLEX project: novel endo-surgical technique for early cancer	Adela Brigic
1210	Questions	
Debate Chair: Robin Phillips		
1220	Quality metrics for colorectal cancer surgery	Omar Faiz
1235	Debate: Outcomes for individual surgeons should be published	For: Graham Williams Against: John Northover
1300	Questions to debaters and vote	
1315	Lunch	
	AGM	
Session 3: Improvement through better quality control, training and collaboration Chair: Adam Haycock		
1415	JAG paves the way for service based accreditation	John Stebbing
1430	Creating a more safe environment for surgical and endoscopic procedures	Manmeet Matharoo
1445	Questions	
1500	Training trainers is the most efficient way to deliver better training	Roland Valori
1515	The transformation of laparoscopic colorectal surgery	Mark Coleman
1530	Questions	
1545	Getting everyone on board: collaboration and effective leaderships is at the heart of service transformation	Roger Barton
President's Address		
1600	How St Mark's changes the world Chair: Sue Clark	Roland Valori
1630	Tea	

Contact: The Course Manager, St Mark's Hospital & Academic Institute, Northwick Park, Watford Road, Harrow, Middlesex, HA1 3UJ Tel: +44(0)20 8235 4046/48 Fax: 0208235 4039
Email: nwlh-tr.stmarksacademicinstitute@nhs.net Website: http://www.stmarkshospital.org.uk

St Mark's Open House

In conjunction with the St Mark's Association

Friday 9th October 2015

Dinner to be held at The Old Etonian on 8th October

Controversies in Rectal Cancer

Chair: John Northover

0900	Decision making aids in low rectal cancer	David Burling
0925	Is this patient with low rectal cancer reconstructible?	Justin Davies
0950	Who should reconstruct patients with low rectal cancer?	Omar Faiz
1015	The truth regarding functional outcomes	Ellie Bradshaw
1040	**Coffee**	

Chair: Robin Phillips

1110	How should we treat enlarged internal iliac nodes when TME is possible?	Ian Jenkins
1135	Does a colopouch reconstruction really improve function after TME?	Alan Roe
1200	Debate: Transanal TME improves rectal cancer surgery when compared to laparoscopic dissection	For (10 mins): Roel Hompes Against (10 mins): Ian Jenkins Audience Contributions
1240	**AGM / Lunch**	

Complete Mesocolic Excision for Colon Cancer

Chair: Roger Motson

1345	A critical analysis of specimen quality in colon cancer	Phil Quirke
1410	Predicting middle colic vascular anatomy preoperatively and its importance in surgery	Antoni Sergot and Bubby Thava
1435	Surgical strategy in CME	Chris Thorn
1500	How should CME be developed to maximise its benefits	Danilo Miskovic
1525	**Tea**	
1555	**Presidential Address**	Robin Kennedy
1630	**Close**	

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Grand Rounds 2014

10/01/2014 Yih Harn Siaw, Robin Phillips: An Update of Pouchitis Research

17/01/2014 Krishna Moorthy, David Shipway, Michael Fertleman, Omar Faiz: Establishing an oncogeriatrics service for gastrointestinal cancer

24/01/2014 Ana Wilson, Claire Taylor, Sue Clark: GI consequences of cancer treatment

31/01/2014 Andrea Frilling, Omar Faiz: Neuroendocrine Tumors of the Intestinum: Clinical Management in the Era of Personalized Oncology

07/02/2014 Nuha Yassin, Sue Clark: Crohn's Perianal Fistulae

14/02/2014 Ian Johnston, Omar Faiz: Bile Acid Diarrhoea: New concepts and emerging therapies

21/02/2014 Anthony Antoniou Steve Wright, Robin Phillips: The Red Army….Marches Forward

28/02/2014 Adam Humphries, Robin Phillips: The lower GI 2WW referral pathway: Direct to test is best!

07/03/2014 Ryan Chang-ho Choi, Robin Phillips: Ulcerative Colitis Surveillance Program: up date from the local database

21/03/2014 Jamie Murphy, Robin Phillips

28/03/2014 Kinesh Patel, Robin Phillips: Does taking a test make endoscopists the best?

04/04/2014 Emile Tan, Sue Clark: Rectal prolapse: what to do, when to do

11/04/2014 Hutan Ashtafian: The colon: A secret weapon in the war against obesity

25/04/2014 Kay Crook, Robin Phillips: Robotic Colorectal Surgery: is this the future?

02/05/2014 Hannah Middleton, Robin Phillips: Enterocutaneous Fistulas: An Overview

23/05/2014 Tracey Tyrrell, Robin Phillips: Renal function and dysfunction in major surgery in contemporary care

30/05/2014 Marian O'Connor, Robin Phillips: Inflammatory Bowel Disease Nursing

06/06/2014 Sarah Walton, Robin Phillips: Desmoids: The saga continues!

13/06/2014 Peter McDonald, Omar Faiz: Surgeons & Manslaughter

20/06/2014 David Bernardo Ordiz, Omar Faiz: Microbiota-induced immune variation in the colon: implications for disease and therapy

27/06/2014 Franklin Adaba, Robin Phillips: Investigating the pathophysiology and nutritional requirements of patients with mesenteric infarction following restoration of bowel continuity

04/07/2014 George Malietzis, Robin Phillips: Colorectal Cancer and the Body Beautiful

11/07/2014 Nuha Yassin, Robin Phillips: Perianal Crohn's Fistulae: The Unmet Need

18/07/2014 Lillias Maguire, Robin Phillips: Novel risk factors for diverticulitis

25/07/2014 Sue Clark, Robin Phillips: Abdominal wall reconstruction

05/09/2014 University of Sao Paulo, Robin Phillips: GI manifestations of Scleroderma

12/09/2014 Rodrigo Perez, Omar Faiz: Organ Preservation in Rectal Cancer Surgery

19/09/2014 Hannah Glen, Robin Phillips: St Marks Digital Future

24/10/2014 Sue Clark: The John Nicholls Prize for Research 1st Heat

07/11/2014 Harriet Owen, Robin Phillips: Quality of Life with Anal Fistula in reference to Fistulotomy

14/11/2014 Derek Boyle, Robin Phillips: Colonic stenting in acute large bowel obstruction

21/11/2014 Gustavo Rossi, Kennedy: Laparoscopy in perforated diverticulitis

05/12/2014 Anton Emmanuel, Robin Phillips: Is there anything new in functional GI disorders?

12/12/2014 Marian O'Connor & Kay Crook, Robin Phillips: IBD: Patient held records and the Telephone Advice Line Service

Grand Rounds 2015

09/01/2015 Mayur Garg, Robin Phillips: Vitamin D in Inflammatory Bowel Disease: Where are we up to in 2015?

16/01/2015 Rameshshanker Rajaratnam, Robin Phillips: Obscure gastrointestinal bleeding: What is the role of pharmacotherapy

23/01/2015 Sue Clark, Robin Phillips: Inherited Colorectal Cancer

30/01/2015 Siwan Thomas-Gibson, Sue Clark: Early cancer, endoscopic detection and management

06/02/2015 Kay Crook (Clinical Nurse Specialist): Paediatric Patient Held records: Nurses experiences of using them in clinical practice

13/02/2015 Naila Arebi, Robin Phillips: Crohn's Strictures: the long and the short of it

27/02/2015 Salman Rana, Robin Phillips: Serrated Polyposis

06/03/2015 Jamasp Dastur, Robin Phillips: Enterocutaneous fistula update

13/03/2015 Andrew Currie, Robin Phillips: Chicken or Egg? Laparoscopic surgery in enhanced recovery

20/03/2015 Alan Askari, Robin Phillips: Colorectal cancer outcomes, a National Study

27/03/2015 Fareed Iqbal, Sue Clark: Chronic Constipation: evaluation of existing and novel therapies

10/04/2015 Janindra Warusavitarne, Robin Phillips: Rectal Prolapse: How should we assess and treat the falling bottom?

17/04/2015 Ravi Misra, Janindra Warusavitarne: Evolving epidemiology in IBD: a focus on ethnic diversity

24/04/2015 Ayesha Akbar, Robin Phillips: Enhancing the physician-patient interaction: Motivational Interviewing

01/05/2015 Brigitte Collins, Patricia Evans, Ellie Bradshaw, Avril Burns, Diane Brundrett, Carolynne Vaizey: Developments in biofeedback: The bottom line

08/05/2015 Andrew Latchford, Robin Phillips

15/05/2015 Mark Thursz Imperial College, Robin Phillips: Where now for alcoholic hepatitis post STOPAH?

22/05/2015 Yoji Takeuchi, Siwan Thomas-Gibson: Effective Management of Colorectal Polyps

05/06/2015 Simha Srinivasaiah, Robin Phillips: Thrombo-prophylaxis in cancer surgery: Are we doing less?

12/06/2015 Jose Perea Garcia Madrid, Robin Phillips: Clinical and Molecular Characterization of Familial Colorectal Cancer Forms

19/06/2015 Tracey Tyrrell, Janindra Warusavitarne: Living with IBD: IBD Nurse perspective

26/06/2015 Alex Leo Sanjeev Samaranayake, Omar Faiz: SILS (Single Incision Laparoscopic Surgery) of the colon and rectum

03/07/2015 Zoran Krivokapic Serbia, Robin Phillips: Strategy of treatment and outcome for T4 rectal cancer

10/07/2015 Peter Gibson, Heidi Staudacher, Jessica Biesiekierski, Robin Phillips: FODMAPS and Gluten: Facts or Fiction

17/07/2015 Marian O'Connor Tracey Tyrrell, Robin Phillips: IBD CNS Service Annual Report

24/07/2015 John Nik Ding, Robin Phillips: Journey to the Centre of St Marks: The personalisation of medical therapy for Crohn's disease

04/09/2015 Nicholas Talley, Robin Phillips: New Insights into Functional Dyspepsia

11/09/2015 James Kinross, Omar Faiz: Metabolic phenotyping in colorectal cancer

18/09/2015 Simha Srinivasaiah, Robin Phillips: Decision making in cancer care: A global perspective

25/09/2015 Prof Paul Pevsner, Michele Marshall: Radiolabelled Nanoparticles and their role in detection and treatment of colorectal cancer

16/10/2015 Samuel Adegbola, Robin Phillips: Fistula-in-ano: concepts in pathogenesis and emerging treatments

23/10/2015 Kapil Sahnan, Robin Phillips: A history of anorectal sepsis in the UK

30/10/2015 Sue Clark: The John Nicholls Prize for Research

06/11/2015 Sue Clark: The John Nicholls Prize for Research

13/11/2015 Tariq Mughal, Robin Phillips: Precision Medicine for Cancer

20/11/2015 Mayur Garg, Robin Phillips: The Renin-Angiotensin System in Inflammatory Bowel Disease: An Old Dog with New Tricks?

04/12/2015 Adam Stearns, Robin Phillips: How does the gut know it is lunch time?

11/12/2015 James Alexander, Robin Phillips: The gut microbiome and colorectal cancer

50 Years Ago This Year: The Staff of 1964 & 1965

Annual Report 1964 staff list

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*Mrs. E. Hailstone, J.P., Vice-Chairman.
*Sir Desmond Morton, K.C.B., C.M.G., M.C., Chairman of the Board of Governors.
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Mr. A. H. Brewin.
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*also members of the Board of Governors.

The Committee had great pleasure in receiving Alderman C. J. Harman, C.B.E., J.P., the Right Honourable the Lord Mayor of London when he visited the Hospital in his capacity as Patron on the 2nd July. Unfortunately the Lady Mayoress was prevented from attending due to ill health, but the Sheriffs and their Ladies accompanied the Lord Mayor.

During the year under review, the Committee has lost three of its most devoted members owing to retirement: Mr. Robert Parker Chambers, F.C.A., His Honour J. Norman Daynes, Q.C., and Mr. A. H. Brewin, all of whom served the Committee with distinction, both after nationalization and prior to this in the days when St. Mark's was a Voluntary Hospital. At the time of his retirement, Mr. Chambers held the office of Chairman and his financial acumen and wide connections with the City Livery Companies were invaluable.

His Honour J. Norman Daynes held the Chairmanship prior to Mr. Chambers and was instrumental in steering the hospital through times of exceptional difficulties. Mr. Brewin and his father before him, gave devoted service to the Hospital. The Committee is greatly indebted to all three for so ably helping with the task of guiding the destiny of St. Mark's during a long and difficult period in its history.

50 years ago this year: The staff of 1964 & 1965


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Oswald Lloyd-Davies


Henry Thompson


Hugh Lockhart-Mummery


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Basil Morson


Donald Bateman


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Honorary Clinical Assistants:
The following have acted as Honorary Clinical Assistants during the year:—
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J. C. BULL, Esq., M.B., B.S., F.R.C.S.

HOUSE COMMITTEE

It is with deep regret that the Committee has to report its grievous loss in the death of Mr. Richard Parker in August 1965. The Committee wishes to record its appreciation of the invaluable service given by Mr. Parker, as a member and later as its Chairman. He will long be remembered for his able conduct of the Chair and as a person ever ready to help his fellow Committee Members, the patients, and staff of the hospital.

50 years ago this year: The staff of 1964 & 1965*

John Lennard-Jones

RNG Atherstone

Leon Kaufman

The final operating list of William Gabriel, December 1958.

This older photograph shows some near-contemporary portraits of several of the staff from the mid-1960s period. Top row left to right: Henry Thompson, Hugh Lockhart-Mummery, John Goligher, Ian Todd, Basil Morson, Alan Parks, Donald Bateman (anaesthetist). Bottom row left to right: Cuthbert Dukes, Edward TC Milligan, Clifford Naunton Morgan, William B Gabriel, Oswald Vaughan Lloyd-Davies, Dr Frankis Evans.

** Photographs could not be located for N Courtenay Evans, Allan C Young, FE Clynick*